

Health Care Reform: A Recurring Theme

Joyce S. McMahon

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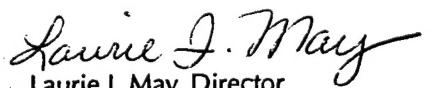
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Laurie J. May
Laurie J. May, Director
Medical Team
Support Planning and Management Division

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Summary

We will not make fundamental progress at reforming the health care system until we, as a nation, come to grips with the issue of how we should ration care. Although we have not been able to come to a consensus on this issue, we remain uncomfortable with our current hybrid system that is a mix of government programs and market options. Recent attempts at comprehensive reform failed because of a lack of agreement on the appropriate shape of reform. These experiences are specifically of interest to those engaged in policy-making with regard to the ongoing evolution of the U.S. health care system. However, we are all likely to be affected by policy changes that alter our health care system, and it is important to understand what happened during our recent effort to seek health care reform and what is likely to occur in the future.

To understand the issues underlying health care reform and the likely future of the American health care system, this paper addresses the following questions:

- What is the history of health care reform for the United States?
- Why did we reengage health care reform in recent years?
- What factors caused health care reform efforts to fail?
- Does our health care system have major problems?
 - Have we begun to fix the problems?
 - Or have we decided that we don't know what to do yet?
- How do we compare to other countries?
- Will health care reform come back again, and, if so, what are the questions we need to answer before then?

Our country is struggling with the issue of health care reform and the broader issue of how best to provide health care services to our

people. In this paper, we formulate the issues to bring the proper questions into focus. To learn why we have difficulty in coming to grips with the issues, we examine how the nation has gone about defining and executing health care reform. We need to be able to understand what problems we have in health care delivery, and what kinds of solutions we can reasonably seek. We also have to face the question of costs: What do we pay now, and how will this change as we modify our health care system?

Health care reform is not a new issue—in this country or in others. Before our recent debate on health care reform, we had addressed the issue of national health care at least four times in this century. Although we have brought certain subgroups under the umbrella of national coverage, starting in 1965 with Medicare and Medicaid, each effort has been met with fierce resistance from special interest groups. Our current system is a hybrid: 26 percent of our people are covered mainly by the government, with another 14 percent having no formal coverage, leaving 60 percent covered mainly through employer-driven insurance mechanisms that vary in type and quality of coverage. In contrast, many other industrialized nations (such as Canada, Britain, and Germany) have chosen national health coverage. Yet they spend less per capita, and a smaller percentage of gross domestic product, on health care services than the United States does.

Our fifth major effort at crafting health care reform has brought many of the same old issues back to the table. In a national sense, at the moment we have repeated the experience of the early 1970s: We have concluded that, although it would be nice to cover everybody, we can't afford to do so. Our focus has switched to trying to control costs, with Medicare and Medicaid as the main targets. On the private side, insurers, employees, and employers are negotiating new ways of providing health care, largely aimed at reducing cost, or at least reducing cost growth. State efforts at reform have also switched to focusing on changing the provision and administration of Medicaid, with lack of coverage pushed aside for the moment.

We find that the following two questions are central to dealing with the recurring issue of health care reform. First, how do we want to

ration health care by a mechanism other than the market? Do we think that health care provision is so different from other goods and services that we do not trust the price system (and associated markets, such as insurers) to ration health care appropriately? Unless the answer is no, we do not need to proceed with reform efforts, but we may want to consider dismantling or modifying Medicare and Medicaid. Second, in addressing the issue of how we want to provide health care services, do we think it is appropriate and efficient to treat everyone the same under a single set of guidelines? This would fit the umbrella approach of some type of single-payer, universal coverage. Alternatively, we may conclude that different levels of health care services are appropriate for different subgroups of our population, or at least that such a solution is all we can afford. As a nation, we must address these questions before we can move forward on the issue of health care reform.

Introduction

Our recent efforts at crafting health care reform highlight the fact that, as a nation, we have failed to identify and assess the fundamental issue of how medical services should be rationed or allocated. Because we have not implemented policies to solve our health care problems, it is likely that health care reform issues will reappear on the agenda in the future. It is essential that we try to understand what happened—and what did not happen—during our recent effort to reform health care. This will provide us with valuable information for future policy-making efforts.

In terms of national health care reform, at least of the type that would provide greatly widened or universal coverage, the issue is politically dormant at this time. For state reform efforts, any type of universal coverage appears to be infeasible as well, for a number of reasons. However, it is important to review the recent experience with health care reform efforts.

First, health care reform is not a new effort; national health insurance has been sought in the United States since the Progressive Era of Theodore Roosevelt. The creation of Medicare and Medicaid in 1965 was partly the result of the effort to provide health insurance coverage to all people, though the general effort to provide universal coverage began decades earlier.

Second, there are substantive reasons why the issue of health care reform and increased health care coverage keep being raised. These reasons are not diminishing; rather, they are increasing in magnitude, and are unlikely to be resolved by our current health care system. These reasons include the growing proportion of our population, especially our children, who do not have access to adequate health care and/or health insurance coverage. There are concerns about allowing untreated health problems to become so severe that people become unproductive or need expensive subsidized

health care. There is also concern about the rapidly growing cost of providing health care, which uses up an increasing proportion of our gross domestic product (GDP). These are related issues: Do the eventual costs of treating those with no coverage add to our growing costs of providing medical care disproportionately, or does not providing coverage help keep our costs from growing even more rapidly?

Third, many other industrialized nations grapple with the issue of health care costs, and yet offer health coverage to the full population. Although politicians are quick to assert that the United States has the "best health care system in the world," it is not in fact clear what this statement means. If it means that we have the best care available for those who can afford to pay for it, the claim has certain merit. If it implies that all people in the United States have access to health care that is better than the care generally available to people in other industrialized nations, this is less clear. And, in fact, it is not clear how we can even make valid comparisons of the quality (and quantity) of health care received under different aspects of our own health care system, much less make valid comparisons across countries. Using gross measures, such as infant mortality rates, longevity of population, and disease rates, we do not have the most healthy people in the industrialized world.¹ However, it is also not clear how well these rates measure overall health, and whether they can be adequately adjusted to take different demographic circumstances into consideration.

Health care reform means different things to different people, which may help explain our inability to agree on what kind of health care reform we want. To define reform, first we must define the problems. Although we can identify a number of problems, the question is, which problems do we think have priority? And can they be solved simultaneously? There are at least three major problems with the health care system:

- Lack of health care coverage for a substantial share of our population

1. Reference [1, p. 107] ranks American males 15th in life expectancy and American females 7th. More than a dozen countries have lower infant mortality rates than the United States.

- Rapidly rising health care costs that take up a greater share of our budget(s)
- A growing dependency on the government to pay for health care.

Therefore, one person may view health care reform as finding a way to reduce the growth rate of insurance premiums, while another views it as offering subsidized insurance to low-income workers. Others may view reform as reducing our dependency on Medicaid and/or Medicare. This fundamental lack of agreement on what is wrong, and what needs to be fixed, lies at the root of the inability to come to grips with health care reform.

Although we will try to look at the overall provision of health care, and consider the links between coverage and cost, we will focus on the issue of providing health insurance coverage for those who have no safety net. At the same time, we will examine current trends in our health care system, especially with regard to costs, since these trends influence the ways in which health care coverage is supplied to various subgroups of our population.

National efforts to affect the provision of health care are still taking place, but they do not generally address universal coverage issues—that is, increasing the percentage of our population that has health insurance coverage. Most national efforts at this time are aimed at regulatory reform, such as limiting insurers' use of preexisting conditions or providing smoother transfers between private insurance plans for people who change jobs. In addition, there are a number of different state reform efforts in play, covering a full menu of plans that vary in type and substance.

However, health care evolution is still taking place, with or without government intervention or assistance. Most people in the United States with private health insurance obtain it via employer-offered benefit packages. And, faced with the rising cost of providing health care coverage, employers and insurance companies are working to find ways to hold down the cost of providing health care coverage. Efforts to control costs generally rely on methods to:

- Shift more direct costs to consumers (deductibles, copayments, denied services)

- Divert care to lower cost methods (substituting outpatient for inpatient care)
- Restrict patient choice of services (rely on health maintenance organizations (HMOs) or preferred provider networks)
- Make gatekeeper arrangements for approving care and restrict access to specialists.

Therefore, the underlying issues of lack of coverage and cost of coverage have not vanished. In fact, reliance on the private sector to find solutions is likely to result in reducing the cost to employers, possibly by shifting costs to employees. There may be a tendency to have less coverage offered and to cover fewer employees. This will mean higher costs for employees, and the net result for society is unclear. The cost of health care must take into account not only the cost of insurance premiums and the cost to the government to provide and subsidize health care, but also the costs absorbed by individual citizens. In fact, if people fail to obtain appropriate health care, as a function of lack of resources to pay, there may be long-run costs to our society that are not immediately obvious, but certainly not trivial.²

In this paper we lay out the relevant issues by reviewing the history of health care reform in this country, and (briefly) for other countries. Our main emphasis is on recent efforts to implement national and state health care reform. Health care reform has been an issue for the United States for many decades and is still relevant. The factors that cause us concern about the future of our health care system remain. Finally, our health care system is changing whether we like it or not. The real question may become whether we want it to change as a function of market pressures in the private sector or with government intervention.

We do not address the function and scope of centralized governments. We have a centralized government and, as a nation, have concluded that some functions are best served by such a system. The

2. People may postpone care until conditions are too serious to ignore, may neglect preventive care, or may fail to get routine care, such as by not taking medications.

question for our society to decide is, Do we think the provision of health care should be allocated by the private market system, strictly provided by government, or some mixture of both? Is health care a special or unique good that involves such considerations as equity issues that make it appropriate for the government to intervene? Medicare and Medicaid are indications that we have chosen to use a mixed health care system. Therefore, the relevant question becomes, How much government influence do we think is appropriate, how should it be applied, and to (or for) whom? And, by the way, which way of providing health care is most efficient?

History of health care reform efforts in the United States

Health care used to be a matter between physician, hospital, and patient. However, the increasing complexity of society, the rise of the insurance system (starting in the 1930s, and accelerating after the Second World War), and the greatly improved sophistication of the delivery of health care services have interacted to drastically alter this simple relationship. Today, if a person does not have health insurance, he or she is considered to be greatly at risk in the health care market. A person of moderate means can be financially stretched by even a modest incident requiring hospitalization, such as a traffic accident with broken bones and a concussion, while a more severe problem, such as cancer or heart disease, can quickly exhaust all the person's financial resources. Many health care episodes cost thousands of dollars—even a simple vaginal birth costs more than \$6,000 today [2].³ A complication during childbirth can quickly lead to serious financial difficulties for an uninsured or underinsured family, with costs of \$11,000 or more.

National health care reform efforts

Before the most recent effort, major health care reform was attempted four times in the United States, starting in 1912.⁴ President Franklin Roosevelt feared that compulsory health insurance

3. Average charges for an uncomplicated vaginal birth in the United States in 1993 were \$6,430, not including prenatal care and testing. The total cost for a Cesarean section averaged \$11,000. Costs are based on Metropolitan Life Insurance Company data and include costs at the time of delivery and for the hospital stay.
4. The four tries were in the Progressive Era, during the New Deal, under President Truman, and during the early 1970s, according to [1].

would rouse such opposition from the American Medical Association (AMA) that it might doom his package of proposals, so he abandoned it (1935). In 1948, President Truman included national health insurance among proposals for the Fair Deal. Although public polls indicated general support for national health insurance, his plans met strong opposition; opponents successfully equated national health insurance with socialism and communism, which proved fatal. Truman's ideas resurfaced with the goal to provide health insurance to the elderly, which eventually led to the Medicare program in 1965.

The health care reform issue was visited again in 1973, when many claims were offered as reasons for the need to implement national reform. The following are representative of the issues of concern:

- Health care costs are soaring out of control.
- Health costs soak up an ever-increasing share of GNP (GDP).
- Many people have no health care coverage.
- Children are going without medicine and care.

The claims first offered in 1972–1973 mirror the arguments forwarded in 1993–1994. At one point in 1973, many people felt that Congress was on the verge of adopting some kind of national health legislation. Various plans were promoted by different factions, including catastrophic coverage, a Canadian-style single-payer plan, and mandated health insurance for working people (supported by the Nixon administration). These efforts evaporated, and by 1974 focus had switched to cost instead of coverage. The arguments of the early 1970s give an eerie preview of the debate of the early 1990s: the names, dollar amounts, and statistics vary, but the issues and the heated rhetoric are comparable. And, as reported in *Understanding Health Care Reform* [1], “reforms failed because shifting coalitions defeated every attempt at compromise.”

Those committed to reform could not agree on a single proposal, which made reform vulnerable to attack from various interest groups. From being certain that national health care reform of some type was imminent, the nation 2 years later was focused on finding ways to control costs and save money, with no serious consideration of trying to

provide national health coverage. The view was that the provision of national coverage would greatly increase costs, and was therefore unworkable.

What arguments in favor of national health insurance were offered in the early 1970s? Again, the arguments sound strikingly familiar. The United States spent a greater proportion of GDP on health care expenditures than most other industrialized nations: 7.4 percent compared to 4.5 percent for Great Britain, for example, in 1970.⁵ At this time, before Canada's reforms of 1971, Canada spent 7.1 percent of GDP on health care. Also of concern were estimates of a large number of people with no health insurance coverage.

National health care reform efforts in the early 1990s

By 1990, the earlier numbers of concern appear paltry. As shown in figure 1, the United States spent 12.4 percent of GDP on health care expenditures, the highest percentage of any industrialized nation, while Canada spent only 9 percent. In fact, most countries spent a greater proportion of GDP on health care expenditures in 1990 compared to 1970. Of the countries examined, however, the United States showed the most pronounced increase: a growth of 67 percent over the two-decade period. While the struggle to contain health care costs is common to many countries, the United States appears to have met the struggle with relatively little success. At the state level, spending on Medicaid has increased rapidly, to the point that 18 percent of state budgets are devoted to Medicaid [3]. This places great pressure on states because other programs are being squeezed by the growing demands of Medicaid.

Figure 2 shows that, in 1991, per capita spending on health care in the United States was \$2,868, while in Canada, our closest competitor, it was \$1,915. Germany and France spent around \$1,650 per capita, Japan spent about \$1,300, and Great Britain was measured at \$1,043 per capita. While one can argue that the United States clearly has extremely good health care facilities and personnel, the magnitude of per capita differences in spending raises the issue of how superior our

5. These numbers and following statistics are taken from [1], pp. 2-3.

system is to these other countries' systems. How much better are our services? Are our citizens that much more healthy? What extra benefits are we getting for our money, and who is getting them? At this per capita rate, it is estimated that, in 1992, 37 million Americans had no health insurance, and that about 17 percent of workers (14 percent of the population) did not have health insurance.

Figure 1. Percentage of gross domestic product spent on health care: 1990

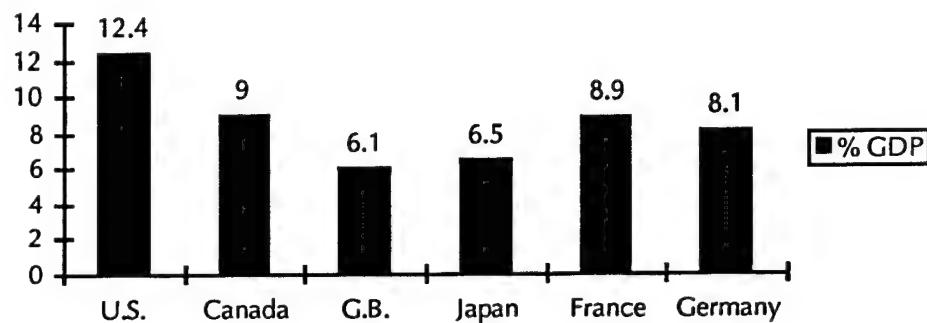
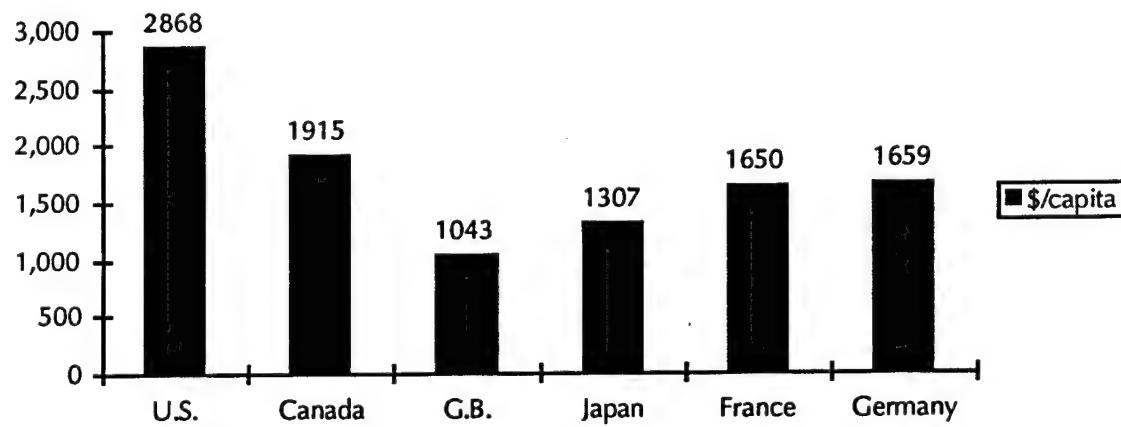


Figure 2. Per capita spending on health care: 1991



In the early 1990s, national efforts at health care reform were widely supported by the American public, based on polling results, and by leaders of both political parties. President Clinton campaigned partly on the basis of providing national health coverage. Although democratic and republican leaders had different ideas about what type of health care reform was appropriate, there was an apparent agreement that unspecified health care reform was needed.

Given this apparent strong support for (some unspecified) health care reform, what happened? First, the details of proposed reforms began to trickle out, and then debate exploded over what the details would mean for coverage, access, and costs. In part, we have incomplete information about the cost that would be entailed by a new system of health coverage: after all, if it hasn't been done, we don't really know how much it will cost. In addition, much of our information is based on data from years ago; timely data are lacking.⁶ However, people were soon inundated with conflicting information, much of which appeared to directly contradict previous information. People were overwhelmed and did not know what to believe. Would a system of national coverage cost more or less—at least in the long run after it got established? How would it get paid for? Would people have to give up their current coverage?

Most people find conflicting claims and counterclaims bewildering. How do we know which statement is correct? Many people have ingrained beliefs that make it difficult to dispassionately evaluate proposals.⁷ In addition to this, there are cultural myths that are accepted as givens in the approach to health care reform that take certain proposals “off the table” politically. One of the best examples for these points are widely publicized assertions that the British and Canadian health care systems are:

6. One of the richest sources of data, the National Medical Expenditure Survey, was taken every 5 years. At the time of the reform debate, the latest data available were for 1987. Efforts are under way to do this survey more frequently.
7. For example, socialized medicine is wrong and should be avoided. Those who make this judgment usually deny that we have any element of socialized medicine, such as found in Medicare or Medicaid.

- Fatally flawed
- Representative of socialized medicine
- Incapable of providing adequate health care
- Creating unconstrained demand, which swamps the system
- Systems completely different from anything used in the United States at this time
- Representing a far different type of people, and so could not possibly apply to the United States.

These and other arguments are simply asserted to be true, with no attention given to weighing the evidence, or examining the facts. Arguments are often based on the anecdotal level of cases that have been reported in the press. If we leap to judgment on the basis of isolated cases, we would have reason to avoid ever entering our own hospitals, for fear of having the wrong leg cut off or of having the wrong side of our brain operated on. In general, the process quickly became politicized, with misinformation becoming part of the political strategy of opponents to reform.

Therefore, a serious look at the Canadian system, for example, was ruled out of the game at the time of Clinton's look at health care reform [1, pp. 159–169]. Equally, the United States system is built on the concept of "employer provided" health care insurance. Buried in this concept is the idea that in such a system the employer pays for the insurance. At no point have we acknowledged that people pay for insurance, whether through an employer filter or not.

Employers, especially those with many employees, are able to contract with insurance companies to acquire group rates, which may be less than rates available to individual purchasers of insurance. However, the idea that the company foots the bill, as opposed to the employee, is wrong. Arguments about premium-sharing percentages derive from employee perceptions that employers pay the "employer share" of the premium and that employee wages are unaffected by this cost. Eventually employee wages are depressed by continued increases in premium costs that are "absorbed" by employers.

National health care reform plans

The Clinton Health Care Reform (CHCR) plan was the administration's hope for national health care coverage. It relied on a system of regional health care alliances, employer mandates to provide some share of the cost for health care coverage,⁸ which would eventually be passed on to employees via lower wages, and a somewhat complicated system of financing. The alliances were essentially purchasing cooperatives: they would offer standard benefit packages, at specified group rates. Employers could provide their current plan, as long as it was superior to the minimum plan set by an alliance. Employers could also purchase health coverage for their employees through the alliance. This opened up opportunities for small businesses to obtain the same (lower) group rates available to large companies, and also opened up avenues for individuals to purchase at group rates. In addition, Medicaid was to pay premiums to the alliance. In [4], DiIulio and Nathan offer a brief discussion of the CHCR plan and five other plans, with regard to details, financial consideration, regulations, and tax incentives.

The CHCR plan was detailed, complex, and difficult to understand; partly because of this, it was open to attack by many parties. The plan would have required changes in the current system for many people, although many of the changes to individuals would have been minimal. However, the plan was a disaster in terms of political salability. It was not understood by the average citizen, or by the media, and quickly became a target of ridicule.

As soon as the Clinton plan appeared, many alternative plans were offered. Republicans offered fierce opposition and alternatives to the Clinton plan, but there were also several alternative democratic plans. Democrats could reach no agreement to support the Clinton plan, and

8. The employer mandates included (a) 80 percent or more of average premiums for employees and dependents up to total payroll caps (adjusted for two-income families), (b) sliding caps for firms with average wages less than \$24,000, to a minimum of 3.5 percent for those with average wages less than \$12,000, and (c) prorated contribution for part-time workers [4, p. 21].

no consensus to support any other particular plan. Widely varying cost estimates were produced, along with financing concerns. Republicans responded by offering a series of reforms that were regulatory in nature, rather than focusing on providing increased coverage.

As these issues began to be debated, the mood of the voters began to reflect the uncertainty evident in the political environment. Many special interest groups did not want to see health care reform take place unless it would directly benefit them. The consequence was that many widely diverse groups took aim at the various health care reform proposals, leading the public to become uneasy and fearful about the impact of reform. These attacks were heavily targeted for television and radio spots. For example:

- Dental coverage is not part of Plan X. People who have dental coverage with their employer health plan will lose it. You gave up wage increases to get your dental coverage. *Don't give up dental coverage to get bad health care reform.*
- Plan X would create an untested bureaucracy to try to run the system. *Do you trust the government bureaucracy to make decisions for you and your family's health?*
- Chiropractic care is not being covered. No plan that fails to cover chiropractic (mental health, etc.) care can be considered adequate. *Vote no until we get a plan that does it right.*
- Plan X would take away the ability of physicians to care for their patients, forcing them into a bureaucratic world of regulations and paperwork, with the patients' needs forgotten. *Physicians will have no time to spend with their patients.*
- Plan X will take away your rights to choose your own doctor, and decide what kind of care you need to have. *Do you want to give up your right to choice?*

This is a small sampling of the claims that were made. Various advertisements fed upon the fears of those who did have health care coverage, and led them to believe that the CHCR plan and similar efforts would inevitably damage their health care coverage. People felt justifiably concerned that they would have to make sacrifices to afford

health care reform, that their own coverage would be eroded, and that these sacrifices were necessary to expand coverage to those with no insurance. To summarize the response of the general public to the publicity:

- I don't see how this "reform" is going to help me.
- In fact, I think it may hurt me.
- Why would I want to pay more to have fewer benefits?

The public's lack of trust in the CHCR plan quickly became apparent. The results of early polls, in which people said that they wanted health care reform, had to be taken in the context of what the polls did *not* ask. The polls asked if people supported health care reform—but not if people were willing to give up benefits, pay more, and accept restrictions on their access to care to obtain that reform. New polls, taken after the glut of publicity and the opposition fostered by specific interest groups (physicians, pharmacists, etc.), revealed a great sense of unease in the population.

Health care reform slipped down in the polls as a priority for the voters, while the budget deficit and debt became a more serious concern. People were reluctant to make a massive change in the health care system, especially if it required significant government intervention, might affect their ability to keep their current coverage, and might require more tax dollars [5]. And as public support for the CHCR plan faded, support for all of the health care reform bills began to erode as well. People did not know who to believe, amid all the competing claims and counterclaims, and began to distrust the whole issue.

Politicians were quick to respond to the slippage of public support for health care reform. By the fall of 1994, universal health care reform was officially declared dead. The quote attributed to the Nixon era reform efforts could stand as a tag line for the 1990s as well: "Reforms failed because shifting coalitions defeated every attempt at compromise" [1, p. 8]. And, as before, the focus quickly shifted, not to providing more coverage, but to trying to control costs.

In the current political climate, there is little point in trying to evaluate the multitude of plans that were offered. For the immediate

future, it appears unlikely that we will reengage the issue of national health coverage. This is not to say that the issue will not return, or that it will lie dormant for another 20 years. The problems with our health care system have not gone away, and it remains to be seen if the continuing evolution of health care through the private system will alleviate these problems in a substantive way.

State health care reform efforts

What happened here?

At the same time as the push to consider national health care reform, many states were involved in health care reform efforts. Some were very limited in scope, while others were quite ambitious. Others were in the planning stage, but faced a difficult progression through the legislative process. Some had approved plans, but were being held up for lack of funding appropriation, for legal considerations, or pending reconsideration by state legislators.

State health care reform, as a way of addressing national interests, is a flawed process by construction. States can influence only their own populations. States often have citizens who:

- Work in other states, or reside temporarily in other states
- Have spouses who work, or reside, in other states
- Have children who work, reside, or attend school in other states
- Work for a company that employs workers in several states
- Seek health care in a state other than their residence—where they work, or while traveling.

This is not an exhaustive list, but it delineates some of the problems states may encounter in trying to regulate health care coverage for their populations and for visitors seeking health care. With 50 states, we could come up with 50 different solutions to “the health care problem.” Obviously, states face different demographic situations and problems; yet, even with the same people and problems, different states will prefer different solutions. Therefore, there will be issues of

“border” problems and even of city problems for cities that straddle two states, such as Kansas City and St. Louis, Missouri. Also, employers who provide health insurance to employees in firms across states would find state legislation burdensome.

In addition, there is no guarantee of stability in this kind of environment. A state health coverage plan can be changed from year to year, so that provisions that seem to offer protection may be entirely missing the next time the legislature is in session. Of course, this could happen with a national plan, but it would probably be harder to get Congress to make basic changes to a national plan than for states to amend their legislation.

Therefore, it is hardly ideal to think of states being able to solve the national health care crisis. In fact, if a state developed a very good health care plan, and implemented it, there would be a serious potential for citizens of neighboring states with poor plans to immigrate. In addition, firms might also choose to relocate as well: in the long run, all states compete with each other to attract firms. However, the states may be better poised to deal with less sweeping issues, such as applying Medicaid programs or supervising Medicare reforms.

So why were so many states working on health care reform? One answer is that, for many states, the reforms were very limited slices of the health care picture and were designed to deal with very specific problems. Another answer is that, in many cases, the states felt that national health care reform was imminent, and they wanted to be poised to tailor state programs to tie to a national program. And finally, in a few cases, it appears that the states were prepared to try to provide increased coverage without waiting for a national program to appear—possibly thinking that a national program might take another few decades to develop.

Recent changes in state strategies

In the past year, states have demonstrated a considerable change of focus. The efforts to provide increased coverage have slipped, and other efforts are being redrawn as well. Why are state activities being reconsidered? The list of answers includes:

- Negative effects of the Employee Retirement Income Security Act (ERISA)
- National shift in focus
- State-level reevaluations—realities of looking at costs, feasibility
- Medicaid/Medicare changes.

States with ambitions to develop universal coverage were, in general, still dealing with an assumption in mind—that ERISA would be modified, or amended, to allow for state exemptions. ERISA was enacted in 1974, essentially to deal with pension plan mismanagement problems. However, the law applies to all employee benefit plans, which includes health care plans. The difficulty with ERISA lies in section 514, the preemption clause, which states that ERISA provisions are to supersede all state laws “insofar as they may now or hereafter relate to any employee benefit plan...” [3]. States are allowed to regulate traditional health insurers, but ERISA will not allow a state to categorize a self-insured employee benefit plan as an insurer, thereby bringing it under state jurisdiction.

The language of section 514 clearly limits states from enforcing laws (other than regulation of traditional insurance carriers) that “have an intended and direct impact on self-funded employee plans” [3]. However, it is also not clear how indirect effects are to be treated. In addition to areas where ERISA clearly forbids state regulation, there are many gray areas of uncertainty, awaiting definitive court rulings, which cast a chilling effect on state reform efforts. Among the forbidden areas are [6, No. 13]:

- Employer mandates
- Regulation of self-insured employer health plans
- Insurance market reforms that affect self-insured plans.

Among the gray areas are:

- Pay-or-play plans
- Income taxes to finance coverage expansion
- Provider taxes

- Uniform data reporting and/or claims procedures
- Status of stop-loss plans (if they are judged to be insured plans, they are subject to regulation).

ERISA has not been modified, and modifications appear extremely unlikely to occur in the current political circumstances. In fact, in retrospect, it appears unlikely to occur under almost any political scenario because repeal or an amendment to weaken ERISA lacks support by either political party. In addition, ERISA also inhibits states' ability to enforce incremental insurance reform efforts. Therefore, ERISA acts to stop many types of actions states have attempted to execute.⁹ For a more complete description of ERISA issues, see the appendix.

In addition to ERISA now being viewed as a stopper of many state reforms, especially those intended to have a broad impact or to achieve a move toward widened coverage, there are other pitfalls that have become apparent in the state health care reform movement. These are not problems with coordination across different states, which would undoubtedly arise over time if state reforms became broadly implemented. Rather, these are problems within a given state across time, in being able to reach broad agreement on a plan, design a financing scheme, get the details approved by the legislature, get initial funding appropriated, and then have the agreement remain stable in the next political year.

Many states are having difficulty at the legislative level, in getting agreement on what needs to be done, and on how best to do it. In addition, if a state legislature approves a given program, the next session may see a reversal or modification of the program. In terms of stability, there are no guarantees, and in fact no plan may ever get fully implemented or tested because it will be changed or killed before it reaches fruition.

9. For example, ERISA has largely stopped the New Jersey rate-setting system (federal district court ruling), and a major part of New York's regulatory setting was eliminated on similar rulings. See [4, pp. 74-75].

Another issue is the lack of national health care reform. Many states saw themselves as waiting to tie into a national structure that would give stability and a defined target to shoot at. With the lack of a national template, many states are rethinking the issue of providing health care reform. Now individual states are facing planning and providing the entire package.

In addition, states are now gearing up to deal with proposed federal changes to the implementation of one of their largest responsibilities: the provision of Medicaid support to the poor. The proposals would require considerable changes in state Medicaid infrastructure and implementation. In one version, states would receive federal block grants, which they would then be allowed to administer with considerable latitude. Although this sounds appealing—after all, different states have different problems and needs—it also carries a tremendous responsibility. The lack of a federal template opens the door to many new efforts, and also to new problems and failures.

Depending on how the guidelines for distribution of money to states are determined, some states will benefit in future years, while others may be disadvantaged. If the distribution is driven off the current distribution, for example, states with growing populations of poor people will become severely disadvantaged. In any event, caps on growth of overall federal funding for Medicaid will eventually force states to make hard decisions on how to reconfigure their programs. This will mean decisions on what kinds of care can be provided, and to whom.

One of the first decisions will be whether to adapt to a growing trend of requiring Medicaid recipients to receive all care through an HMO mechanism. In other words, managed-care rationing will arrive at the state level, and may be done differently by each state. Therefore, states have been handed a glimpse of future freedom to control their Medicaid programs, along with some indications of the headaches they are about to inherit.

Potential changes to Medicare also carry problems for the states. The proposed changes in program design, to encourage switching to HMO enrollment for the elderly, do not necessarily involve turning over program administration to states. However, it will be likely to

involve states in more interaction with regulatory issues. Caps on growth of spending will imply that changes must occur. Because the growth in spending is being fueled by the increasing numbers eligible for Medicare, a factor that will continue as the population ages, there are only two ways to limit growth in spending: limit the number becoming eligible, or lower per capita spending. To lower per capita spending, it will probably be necessary to shift additional costs to Medicare recipients. However, there are limits to how much costs can be squeezed via rate reimbursement reductions and similar measures.

This, then, proposes to be a future problem for states. It is speculative at this point in time, but if Medicare is changed to limit cost increases, and people face more personal responsibility for paying for health care, more people may become closed out of the health care system with regard to certain types of care. A year ago, the Health Care Financing Administration (HCFA) was talking about the effort to include prescription drugs under Medicare. There is a positive aspect to this: if prescription drugs come under Medicare, the government becomes a major player in the prescription drug market, with power to elicit compliance with cost-control mechanisms. However, it may be difficult to pull in prescription drugs at the same time the overall benefit is being cut.

If the benefit must be cut, then more of the poor who rely on Medicare as their basic benefit source will face reductions in some aspects of their health care. This may take the form of increased time between office visits, fewer days in the hospital, less diagnostic testing, fewer covered services, and less patient discretion to select physicians and choose care. States may be asked to pick up the slack for those who are falling through the cracks in the federal health care system for the elderly. It seems likely that states would want to provide additional assistance only for those judged to be needy due to poverty and/or extraordinary medical expenses.

Current state activities

Although there are many state reform efforts, we decided to focus on efforts that involve major change or reform. We present a synopsis of three states here, with further details in the appendix. We have

chosen Hawaii, Washington, and Maryland as examples of the types of state activities currently taking place. Hawaii has a long history of health reform and is the only state with an ERISA exemption. Washington had an ambitious plan for universal coverage, which has failed to show much promise as yet. ERISA problems and political realities have hindered implementation and execution of intended programs. Washington provides a good example of the kinds of problems states are having with their reform efforts.

Maryland has programs that have been in the building process for many years, and it has chosen routes of reform that do not require ERISA exemption.¹⁰ Therefore, the experience of Maryland offers an example of viable health care reform at the state level. Maryland is following a plan that involves insurance reform coupled with Medicaid reforms.

The Hawaii health care system

Hawaii is the only state with an exemption from ERISA, and consequently the only state that has been allowed to implement measures to provide near-universal coverage to its citizens. It took over 6 years for Hawaii to obtain its exemption, which was undoubtedly given partly because Hawaii is relatively small and isolated from the rest of the United States. This means that Hawaii's health care reform efforts may offer insights for other states, but they can scarcely be viewed as a general template. Hawaii does not have the inherent problems and pressures that would be faced by other states—adjacent states with different health care systems.

However, even Hawaii's health system leaves holes in terms of universal coverage. The health coverage system still relies on the employment system, and does not require employees to maintain coverage for dependents. Also, there are limits on coverage that, although adequate in most cases, could leave people uncovered in situations of severe health problems. In 1991, while the national average for non-coverage was about 14 percent, only 4 to 7 percent of Hawaii's

10. Maryland considered seeking an ERISA exemption recently for a new reform effort, but decided against this path.

residents were estimated to lack health coverage [7, p. 1]. The employer mandate requires employers and employees to share premium costs, and also requires employees to take self-coverage unless they have equivalent alternative coverage. Part-time workers, government employees, self-employed people, and certain low-income workers are exempted.

What impact has this had on Hawaii? In many respects, not much. Hawaii's rate of growth of health care costs has paralleled that of the United States as a whole. In addition, Hawaii's per capita spending on health care is similar to the national average. What is different is that health insurance premiums are below the national average, and have grown more slowly than the national trend. Also, small-business premiums are similar to premiums for large employers in Hawaii. In general, for the United States, small-business premiums are considerably higher than the premiums paid by large employers.

The main difference is that Hawaii has far fewer people with no health care coverage than is true for the United States as a whole, while keeping per capita costs about the same as for the United States. This means less cost shifting to recover for unreimbursed care. Also, most people are in the same risk pool. If Hawaii can be viewed as a small country, it offers a snapshot of how widened coverage can be provided, without generating large cost increases. However, there could be difficulties if this approach were tried by a state that did not have the benefit of being isolated from other states. For a more detailed discussion of Hawaii's experience, see the appendix.

Washington's efforts at health care reform

Washington's 1993 Health Services Act was an attempt to provide a template for universal coverage for state residents. It included employer and individual mandates for providing and obtaining health coverage, a comprehensive uniform benefits package, and insurance premium caps. The move to universal coverage was to be phased gradually, with full coverage achieved by 2000. The plan also included subsidized health coverage for adults with incomes up to 200 percent of the poverty level and Medicaid expansion for low-income children (in families of up to 200 percent of the poverty

level). Other provisions included market reform efforts to provide guaranteed issue and renewability, limit preexisting condition periods, and require community rating for small businesses and individuals.¹¹

However, there were various factors that affected the execution of the plans, culminating in May 1995, when the legislature voted to repeal much of the 1993 Health Services Act. The experience of Washington State is an example of the difficulties inherent in trying to implement state health care reform. First, the existence of ERISA doomed the use of employer mandates for health coverage. Washington held back on the planned implementation schedule because it was clear that the state could not survive an ERISA challenge [8]. Washington planners had hoped that ERISA would be either amended or modified with a waiver process.

Second, the hazards of relying on state reform are demonstrated by the reversal of much of the planned reform by the new legislature. The May 1995 legislation eliminated employer and individual mandates, the comprehensive uniform benefits package, and insurance premium caps. In addition, the legislature abolished the Health Care Commission and replaced it with a Health Care Policy Board, designed to serve in an advisory capacity.

There are still some measures going forward to expand access to health insurance coverage. These include attempts to expand subsidized insurance and Medicaid coverage for children. In addition, market reform efforts are still in play. However, a reform mandating that coverage be made available, but not constraining the benefit level or the price of the coverage, is not expected to have much impact.

The Maryland health care system

Maryland adopted a regulatory approach to health care, starting in the early 1970s, that has focused mostly on trying to control health

11. The community rating can be modified by age, family size, geography, and "wellness activities." See *State Initiatives in Health Care Reform*, No. 13, [6].

care costs. The first efforts were targeted at the hospital industry, and included the establishment of an all-payer, rate-setting program and a certificate-of-need (CON) program. Maryland recently passed legislation to directly affect insurance companies and physicians. Each regulatory effort is directed by an independent commission, with members appointed by the governor. The three areas examined are hospital rate-setting, hospital capital investment, and insurance and physician payment reform.

Maryland was the first state to attempt "public utility" regulation of hospitals. Our interest is concentrated in its rate review and rate-setting functions. The commission also applied to the Department of Health and Human Services (DHSS) for a waiver from Medicare and Medicaid reimbursement principles in favor of the state's rate-setting system. The DHSS granted Maryland the waiver effective 1 July 1977, at which point the commission achieved control over all payers. Maryland's rates are mandatory and apply to all acute care inpatient, emergency and outpatient services provided by hospitals. The primary goal of Maryland's system is to control hospital costs. In 1976, Maryland's cost per discharge was 26 percent above the national average. By 1992, the cost per discharge was 14 percent below the national average [9, 10].

As a regulator of all payers, the Maryland rate-setting payment system also prevents cost shifting among payers and achieves an equitable distribution of uncompensated care. Typically, Medicare, Medicaid, and Blue Cross do not pay for costs associated with charity care and bad debt. In such cases, the costs of uncompensated care shift to private payers and other insurers. However, under the Maryland system, all payers share the burden of uncompensated care. Also, in a review of the literature on hospital rate-setting, Anderson [11] found that rate-setting systems have achieved expanded access to services for the uninsured. Currently, Maryland is the only state maintaining an all-payer, rate-setting system.

Maryland was among the first states to adopt a certificate-of-need program aimed at controlling the expansion of hospital facilities and services. The main focus of CON programs is to control health care costs by preventing the oversupply of health care resources. CON laws

became more widespread among the states following the passage of the Public Health Service Act of 1974. Maryland's program, which began in 1970, predates this federal legislation. In brief, the act encouraged states to adopt CON laws by tying them to eligibility for federal funds for public health services. During the deregulation efforts of the Reagan administration, Congress repealed the act, effective in 1987. Despite the elimination of federal funding, a number of states, including Maryland, continue to operate CON programs.

On 9 April 1993, Maryland lawmakers enacted legislation that deals with rising health care costs and inadequate access to health insurance coverage through regulation of insurance carriers and health care practitioners [12]. The primary areas of work are:

- Promoting small-group market reform via the introduction of a comprehensive standard health benefit plan
- Developing a medical care database on all nonhospital health care services
- Creating an HMO quality and performance measurement system
- Encouraging administrative simplification via certification of electronic claims clearinghouses
- Developing a resource-based relative value scale (RBRVS) payment system for physicians
- Designing practice parameters specific to the State of Maryland [13].

There are several lessons to be learned from Maryland's experiences in the evolution of its health care system. Maryland chose not to wait for the federal government to take action with respect to health care policies. Each legislative effort was state initiated. Each effort also has had the support of various health care interest groups, though never all of them. The combination of grassroots and business support has been crucial to successful legislative action.

From the beginning, Maryland adopted a regulatory approach to health care reform. The emphasis is on establishing mechanisms to make marketplace forces work. One element that has been critical to Maryland's continuing efforts is its avoidance of ERISA regulations. By focusing on insurance reform rather than employer mandates, Maryland has taken an approach that does not require an ERISA waiver. The appendix gives a considerable amount of additional detail on the three types of regulatory reform adopted by Maryland.

Where do states stand today?

With ERISA as an effective stopper for substantial, universal state health care reform, where do the states move from here? Some reform efforts are allowed, but most of them have limited impact and certainly do not address the broad issue of widening coverage. There are other reform efforts that may, or may not, be allowed: this must be settled definitively by the federal court system. ERISA is definitely hindering mainstream reform efforts that try to widen health care coverage. However, we can argue that this has some positive aspects.

State plans demonstrate many difficulties in implementation, funding, and execution. There are instability aspects of sustaining a program with a changeable state legislature, and severe problems of trying to deal with a very complex problem—the provision of health care services—in isolation of any kind of national direction. In addition, there would be difficulties for states that offer more generous plans than their neighboring states, and to employers who must contend with different rules in each state in which they operate.

Once a law is passed, there tends to be more stability at the federal than at the state level. It is more difficult to pass a national law than a state law, but also more difficult to change a federal law than a state law. Health care reform, insofar as it is an issue that affects the general health of our population, is a national issue. If healthy people are a national resource, and if there are public good aspects to having a healthy and productive population, then a national program is the appropriate venue in which to make policy. If, on the other hand, we decide as a nation that health care is a private matter, best left

between individuals and providers, then it is inappropriate for individual states to interfere in this relationship.

In addition, activities at the federal level may place additional burdens on the states, which will cause many of them to refocus their reform efforts. Changes occurring at two levels may have a direct impact on the course of action taken by states. First, if the federal plan to cut Medicaid and farm out the funding and management of Medicaid to the states is implemented, many states will have unexpected responsibilities to absorb. In fact, many states are beginning to refocus their efforts at the goal of taking control of Medicaid programs.¹² The move to place Medicaid recipients under HMO management will also create new work for the states. In addition, if Medicare funding is cut, states may need to consider programs that will assist the elderly to fill the resulting gaps in service.

States will continue to pursue reform efforts that are allowed by ERISA, but these will largely be regulatory in nature. Such reforms are best suited to trying to control costs and perhaps to widening the availability of insurance to individual purchasers and small business coalitions. It is unlikely that state reform efforts will be effective at providing coverage for all members of their population, in lieu of ERISA reform.

12. This plan was discussed at a conference in Boston, May 4-6, 1995, "States of Change: The Progress of State Health Care Reform" [14].

International comparisons for health care reform

Another way to evaluate our health care system and reform efforts is to compare our choices to those made by similar countries. Canada, France, Germany, Britain, Japan, and Australia provide their citizens with universal health coverage. These are large, industrialized nations. Although they vary in many ways from the systems in place in the United States, there are enough similarities that we should be able to observe lessons learned with regard to health care issues for the United States. These countries provide universal coverage for 8 to 9.5 percent of GNP in the case of Canada, France, and Germany, and 6 to 8 percent for Britain, Japan, and Australia. The United States, while spending 12 percent of GNP for health care, does not measure up in aggregate metrics, such as infant mortality and life expectancy. In these regards, the United States ranks below the members of the Organization for European Cooperation and Development [1].

We will examine two countries in some detail: Canada and Japan. We will look at Canada because of its proximity and similarities to the United States and because we may be able to apply lessons learned from Canada's experience to the United States. We will look at Japan for a different reason: Japan has a very different kind of population and health care system and provides an example of the inherent difficulties in making comparisons across countries.

The Canadian health care system

Partly because Canada is our near neighbor, and partly because Canada resembles the United States in many ways, the Canadian system of health care has come under scrutiny as a possible model the United States could explore. However, there have been frequent attacks on the idea that the Canadian system has any validity for the United States. Such assertions range from attacks on the quality of

health care in Canada, to claims that the Canadian system fails to provide health care in a timely fashion, and assertions that the United States is so different from Canada that it is irrelevant to look at what works for Canada. The truth is, perhaps, that we have an entrenched health care system whose proponents will aggressively resist change, and will fight through the political process and through the media.

Before 1971, the medical care systems in the United States and Canada were very similar. In 1970, as reported earlier in this paper, the United States spent 7.4 percent of GDP on health care, compared to 7.1 percent of GDP for Canada. In 1971, Canada consolidated its national health insurance. The term *national insurance* is something of a misnomer: the 10 provinces of Canada arrange and administer health care, within certain federal guidelines.¹³ So long as these guidelines are met, the federal government will pay about 40 percent of the costs accrued by the provinces for providing health care. The guidelines for the provinces include:

- Universal—covers all citizens
- Comprehensive—covers conventional hospital and medical care
- Accessible—no limits on services, no extra charges to patients
- Portable—can receive care in any other province
- Publicly administered—controlled by public, nonprofit organization.

In terms of gross outcomes measures, such as infant mortality and longevity, Canadians have health as good as or better than U.S. citizens. However, various other assertions have been leveled to accuse the Canadian system of inferior execution:

- Doctor flight to the United States—your doctors, or your best ones, will flee to the United States to practice.
- Use of technology—Canada will lag the world in the adoption of technology.

13. The details that follow are taken from [1], p. 186.

- Rationing—the system rations health care.
- Doctor incomes—Physicians will be unable to earn an adequate living.

Some of these assertions simply do not stand up to scrutiny. The ratio of physicians per capita in Canada, compared to the ratio for the United States, has remained virtually unchanged since the inception of universal coverage in Canada. Physician incomes do not appear to have eroded in Canada since the advent of universal coverage.

The biggest differences in the process of health care services between Canada and the United States are probably that Canada uses much less high-technology testing, treatment, and evaluation, and that Canada's rationing system is based not on ability to pay, but on an assessment of the severity of need for care.¹⁴ Health care that is not urgent may be pushed back to allow physicians to deal with more urgently needed care. However, even in the United States, it may take weeks to get a nonemergency appointment for routine care.

One question has often been asked: could you use the Canadian system, then let people pay extra for extra services? In other words, have a minimum benefit system, but let people supplement for additional care by paying out of pocket? The answer is probably not: this would weaken and invalidate the mechanisms for keeping costs under control. The ability to bargain with hospitals and physicians, and set generally accepted rates, depends on having full control of the health care system. To remove control of part of the system is viewed as opening a hole that would permit costs to escalate and would limit the effectiveness of the entire system.

Japan's health care system

On an outcomes basis, Japan has the healthiest people of just about any nation that is surveyed, with regard to both infant mortality and longevity in particular. However, the assessment of Japan's overall

14. The following example is from [1], p. 188: Cardiac catheterization is 3.4 times more likely to occur in the United States than in Canada. Organ transplant is 1.2 times more likely in the United States than in Canada.

health care system is that the quality of medical care is quite uneven. Some institutions give good care, while others provide more limited types of services. Care varies by geographic location. Those hospitals rated as good tend to be heavily used and, consequently, are over-crowded. Facilities with poorer capabilities and resources, however, may even require patients' families to help with the nursing.

Compared to the U.S. population, the Japanese people have fewer surgeries, and a much greater reliance on the use of prescription drugs.¹⁵ Clearly, they are receiving a different type of health care than is generally provided in the United States. So why are the Japanese people so healthy? Is their system better than ours? One suggested answer appears to derive from Japan's commitment to preventive care—a serious attempt to give prenatal, maternal, and child care to all citizens who need care. This up-front investment is viewed as paying off in later years, by establishing a healthy base of children who will grow up with relatively few health problems. There is a payoff to society as well from the pattern of Japanese society: the relatively even distribution of income and education yields a society of people who apparently do not experience a great deal of serious health problems.

Can the United States learn from the lesson of Japan? Only in the following sense: if you devote large amounts of preventive care, at the beginning of life (maternal, child care), and have a society of well-educated, economically advantaged people, it will probably take less money to provide care for such a group. In comparison, the United States has many people with poor maternal/neonatal care, and a quite uneven distribution of income and education. It is easy to oversimplify the comparisons being made, but it seems fair to say that demographics can make a big difference when comparisons are made

15. According to [1, pp. 197–198], Japanese per capita consumption of prescription drugs is twice that of the United States—probably because of a structure that allows physicians to purchase drugs at a discount, sell directly to consumers, and profit at about 25 percent per prescription. Surgery rates are perhaps a quarter of our rate, but diagnostic testing is widely used. This also relates to the Japanese fee schedule for reimbursement of physicians: ambulatory care and diagnostic tests are favored above surgery.

across countries, or even across disparate groups of people. In addition, it may be difficult to compare outcomes when health care systems are very different in structure, as can be observed for Japan and the United States.

Therefore, in the case of Japan, the health care system it provides is very different from ours, and it has a much different focus. In addition, the demographic diversity appears to be less, with people more homogeneous than is the case for the United States. The result is a society of very healthy people, with an uneven health care system in place to deal with problems that develop. The preventive, early-life health care system, however, seems to be fully engaged. It is not clear that there is much that we can adopt, or would want to adopt, from the Japanese health care system. While we may want to invest more in up-front maternal/neonatal care, and preventive care for mothers and children, we still have a society that has a different demographic dynamic from that apparent in Japan, and it is not clear that we could easily replicate their results.

Problems with the health care system—what concerns remain?

Given the difficulties we have examined regarding attempts at health care reform, at either the national or state level, why does health care reform continue to be an issue? The answer is that there are serious issues about our health care system that remain and may require immediate resolution. We need to understand the issues, and the problems, before we can begin to propose and grapple with solutions. To do this, we need to get accurate information, not the different spins provided by special interest groups, both political and private. A better understanding of the problems and issues may lead us to be able to make decisions about what kind of health reform is appropriate for this country.

Lack of and inadequate health insurance coverage

The issue of those who have no health insurance is important for at least two reasons. One is that there is concern for the well-being of people, especially children, who receive inadequate health care, and who may become unhealthy and unproductive members of society. A second issue is whether these people do in fact receive health care, but of the wrong type and at the wrong time. In other words, do these people receive health care only when conditions have become so severe that the health problems require urgent attention? If so, then care is not avoided, merely deferred, and is consequently more expensive when it is finally given.

In this sense, then, society does subsidize health care for these people, but indirectly—through tax dollars for public clinics, charity reimbursement, and cost shifting by physicians and hospitals to those who can afford to pay directly or via insurance. And the bill may be above average for these people because they failed to receive preventive care or routine attention—resulting in conditions that worsen and

become more difficult to control. For example, high blood pressure, if undetected and uncontrolled, may lead to a stroke, which carries very serious and costly health consequences.

Do we have such high costs because we do not have comprehensive insurance? Or would the extension of health coverage to our uncovered people raise our spending to even higher levels? These issues remain unresolved in the minds of the American people, who have certainly heard a great deal of conflicting "information" in recent years. Does private insurance subsidize Medicaid and/or charity medical costs? Or do most of us receive "too much" health care (unnecessary care and tests that run up costs but do not improve our health)? In the latter case, those who are uncovered may receive less health care, but they may not be substantially affected.

The issue of rationing

Do we want to ration?

The issue of rationing often comes up in the discussion of providing health care for people in the United States. Usually, the question is posed as "Do we want to have to ration health care?" as if this is, first of all, something we do not currently do and, second, an undesirable outcome. The issue of rationing of health care is politically loaded: it touches off a violent emotional reaction in many people. However, the truth is much more prosaic.

In fact, yes, we already ration health care. We ration health care based largely on the ability to pay, through the price system. If private means are large, an almost unlimited amount of health care of the highest possible quality is available. If private insurance is available, the amount and quality of health care available is limited by the terms of the insurance policy, plus the amounts the person is prepared and able to use to supplement covered care. If no private insurance is available, but federal insurance is provided through Medicare or Medicaid, again the level of insurance coverage determines the amount and quality of care

available.¹⁶ Medicare patients may supplement with private policies and out-of-pocket payments, while Medicaid recipients generally do not find this feasible.¹⁷

Finally, those who have no health care coverage can receive care as long as they can pay for it themselves, or find a hospital, physician, emergency room, or public health clinic to provide them care at no cost or minimal cost.¹⁸ With no coverage, a hospital or emergency room may give the patient initial care, especially if an emergency exists, but long-term or maintenance care may be unavailable.¹⁹ Equally, care that would provide an improvement in a patient's condition may also be missing because of lack of funding.

16. Are the people covered under these programs adequately covered? Under Medicare, the government has moved to ensure that all hospitals "accept assignment," which means that they must agree to charges approved by the government. If the hospital rates are above that level, they are required to not charge the patient for the difference in charges, but accept the government level of usual, customary, and reasonable (UCR) cost. There is, however, a substantial deductible for hospitalization. Physicians are not constrained to accept assignment, but many do, and the government provides lists of physicians in each area who will accept assignment. In addition, Medigap policies are available for private purchase, which may pick up some or all of the cost of deductibles for hospitalization and for private physician services and copayments.
17. Medicaid places far fewer constraints on the practices of hospitals and physicians than Medicare does.
18. Callan and Yeager [15] report that many uninsured people do not seek medical care until their condition becomes serious and that, as a result, they require more complex and more expensive care. Many expectant mothers who are uninsured receive no (or minimal) prenatal care before they arrive at a hospital to deliver the baby. This increases the probability of birth complications and health problems for the baby, which also increases costs. These costs get passed along to "paying customers"—largely those with private insurance—in the shape of higher prices for medical care.
19. Patients who come to an emergency room are usually seen, with or without health insurance. If a true emergency exists, the hospital is required to give care, and even if it is not clearly an emergency, hospitals fear lawsuits from turning away people who turn out to be very ill.

One example that receives a great deal of publicity is the transplant process. Many people today can benefit from the advances in technology that permit successful organ transplant. Drawbacks, however, include lack of available organs for transplant and the high cost of such operations. Based on data from the Health Insurance Association of America, costs for the first 5 years for a kidney transplant are \$125,000, while a lung transplant costs \$280,000. A heart transplant costs \$250,000.²⁰ For some types of transplants, many hospitals require a large sum of money to be collected and available for disbursement before scheduling the operation. Many insurance policies, even if available, fail to cover more than a small fraction of the required cost. Some policies routinely deny coverage for many transplant and cancer procedures on the grounds that they are "experimental" and "unproved procedures." Other policies have maximum benefit levels that are exhausted well before the costs of transplants or cancer treatment are covered.²¹ In such cases, the price system determines who gets treatment.

This is not to say that the price system is wrong or evil. Obviously, if a procedure is expensive, the funds must come from somewhere. Physicians, nurses, administrators, secretaries, janitors, lawyers, chaplains, technicians, pharmacists, and blood bank employees depend on paychecks to live, and are in the chain of health care providers. To say that all health care services should be available to all people, regardless of ability to pay, ignores significant realities: health care services use up scarce resources that can be used in other ways. The price system is one way to ration goods and services among alternative uses.

The rationing argument eventually comes back to an issue of how much health care service should be provided, regardless of whether people can pay for their care. In other words, can we define a minimum level of care to which all people are entitled, regardless of ability

20. Data on transplants were developed for 1992 [16].

21. For insurance policies with a high maximum benefit, or very thorough coverage, some transplants are considered cost-effective, with long-run costs less than ongoing treatment. An example is Medicare coverage of kidney transplants.

to pay, and then allow those who can afford to pay to choose higher levels of service? In fact, this is what currently occurs, without the formality of a defined benefit. People who cannot afford to pay seek out services to the best of their ability, with the assistance of Medicaid, charity, family resources, and other public assistance. If they are unable to arrange for care, they do without. Those who can afford to pay usually purchase insurance and then try to cover any extra costs. Those who are faced with truly exceptional costs, such as for transplant surgery or expensive cancer therapy, often must apply to family, friends, and community benefits for assistance.

Taken in the light of this information, we view the question of "do we want to have rationing?" from a different perspective. We do ration—on the basis of who can afford to pay for care or purchase different levels of insurance. The issue is whether we prefer a new kind of rationing—one that will guarantee a minimum of care to everyone, but may result in decreasing the care available to some in the present system. Put another way, does health care differ enough in nature from other goods and services that we do not want to rely on the price system to ration health care?

If so, the question becomes, which groups do we want to ration (or require to absorb more costs), compared to the current system? If we provide a guaranteed minimum to everyone, does this mean that some of the care currently provided must be curtailed? If so, who will be affected, and how? Alternatively, who will have to pay more? Will this be a short- or long-run impact? The fear of rationing is used to avoid change. This is a valid consideration, but it is deceptive to claim that we do not ration health care and should avoid doing so.

Targeting rationing for subgroups of the system

Pressure is increasing to ration health care to some segments of society (the elderly, for example). Medicare is partly funded through taxes, and it is proving very costly. Although part of our rising cost of Medicare is based on the age distribution of our population, which is tilting toward a higher percentage of elderly people, it is not clear that we can blame our health care situation on the elderly. Evidence for other countries does not support the hypothesis that a high

proportion of elderly people necessarily implies high health care costs; however, their systems are structured differently and may not support vast reserves of care for the elderly [17].

Today, Medicare covers about 36 million people. Although we think of Medicare as covering the elderly, based on its coverage at inception in 1966, as of 1972 it also covers some who are disabled or have end-stage renal disease. The Congressional Budget Office (CBO) estimates that Medicare spending for FY 1995 will be about \$176 billion.²² In the last 5 years, Medicare spending has increased from 9 to 11 percent of federal spending. The annual (unadjusted) growth rate over this time frame was 10.5 percent. By 2000, the CBO has estimated that Medicare spending will be at \$286 billion (14 percent of federal spending).

What drives this alarming increase? One major source of the growth in spending comes from the growth of eligibles: between 1990 and 1995, the number of people covered increased by 11 percent. While the per capita spending rose as well, this rate was below the rate of growth for private health insurance holders. This is troublesome because the population eligible for Medicare coverage is projected to rise steadily in coming years. This will fuel increases in Medicare spending, even if the per capita spending is held constant.

Providing health care to the elderly poses several problems to society. First, age is the best predictor of health care expenditures: as people age, their average health care expenditures rise at an accelerating rate. Although the elderly represent only 12 percent of the population, they account for 36 percent of national health care expenditures [18]. Second, the Medicare system offers assistance to pay for health insurance for all elderly, not just those who are poor. In part, this is a reflection of a "failure" of insurance markets: insurers will, if left to their own devices, quite naturally charge the elderly a higher rate for health insurance than will be charged to younger people. Retirees face a difficult situation: as their incomes fall and become relatively

22. These figures and following data are based on materials from a conference on Medicaid and Medicare, "Can We Successfully Restructure the Medicare and Medicaid Programs?" [18].

fixed, and employer-sponsored health insurance is relinquished, they would face a rapidly increasing schedule of premiums to obtain individual private health insurance.

In any event, the third problem is one of magnitude. Medicare has grown costly to maintain, not so much because of increasing costs per capita, but because of the growing numbers eligible for Medicare. However, any attempt to diminish the role or magnitude of Medicare runs into a roadblock—an organized and politically active group of retirees who feel entitled to no less than the status quo with regard to benefits. In fact, the next generation down also tends to give political support to Medicare: if not for Medicare, the care of their elderly parents would fall directly on them. In addition, looking ahead to retirement themselves, they want the reassurance that they, too, will have access to health care insurance upon reaching age 65.²³ These reasons make Medicare a very difficult program to limit or constrain.

One suggestion to reduce Medicare cost per capita is to allow Medicare recipients to sign up to receive care through HMOs, which are widely viewed as holding down costs, partly through constraining access to specialists. The problem with this is that it is unlikely to prove successful for a variety of reasons. First, the legislation enabling HMOs to enroll the elderly has been in place for about two decades.²⁴ A number of HMOs do enroll the elderly, but it is fair to say that there is little demand by the elderly to have access to HMO care. Currently, about 9 percent of Medicare eligibles are enrolled in HMOs, with the bulk of elderly HMO enrollees on the west coast. A more stringent (and politically dangerous) approach suggested is to require Medicare recipients to join HMOs.

Second, the issue of sample selection arises. Of the Medicare eligible, those most likely to participate in an HMO are those who are younger and relatively healthy, not those who already have health problems and/or have established contacts with private physicians. If HMOs

23. Many retire before age 65. These people already face an insurance gap, with very expensive or limited access to health insurance until they qualify for Medicare. This gap is another problem of our health care system.

24. It was established during the Nixon administration (see [19]).

simply enroll the healthiest and youngest of the Medicare group, the remainder under traditional Medicare will have a higher per capita cost, and it is unclear if total costs will fall. We need to investigate the success of our existing HMO-elderly enrollment arrangements to determine how they are working and whether they do act to hold down costs.

HMOs have traditionally served young, healthy families. The working assumption is that HMOs will be successful at reducing the average cost of caring for the elderly people who enroll. This assumption is based on the lower average cost of care for current HMO enrollees compared to cost of care for those under alternative types of coverage. We have very little evidence, as yet, to indicate that HMOs will have success at holding down costs for elderly people with increasingly serious health problems.²⁵ Young, healthy families have far different types of health care needs than are observed in an elderly population.

The choices for controlling Medicare costs are few. We can:

- Chip away at the benefit
- Reduce the eligible pool, by raising the age or disability requirements
- Require beneficiaries to pay more of the costs.

The second major rationing target covers the Medicaid group, which is comparable in size to the Medicare eligibles. The focus of this effort is aimed at enrollment of Medicaid eligibles into HMOs. This would

25. However, if there are eventually successful efforts to place restrictions on the provision of Medicare, there are many implications for society in general. In particular, the Medicare system, if it faces new and stronger restrictions, may become a source of concern for the military health care system. If Medicare becomes less generous, or reliable, as a source of care, eligible people may return to the military treatment facility (MTF) as a last resort. Private insurance, except as a Medicare supplement, is prohibitively expensive for the elderly. If Medicare becomes weak, the only logical course of action is to demand help from the military system and/or the Veterans' Administration.

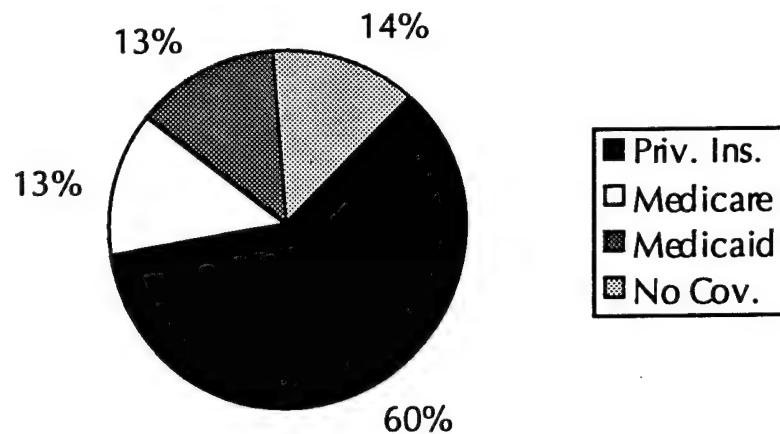
enable better planning and control of costs, and might well improve access for individuals as well. However, for this group of people, the type of care needed is very different and is well suited to the experience of HMOs. Those on Medicaid tend to be young; many are children. They have medical needs that are generally met by access to a family practice physician. In addition, for Medicaid, there is a goal to enroll all of those eligible into the HMO setting, subject to availability. This would bring most of the Medicaid group into a controlled environment, without allowing people to self-select into traditional Medicaid. The standard version of Medicaid might well be reserved for those living in rural environments with no managed-care organizations.

Because of political realities, it is probably not feasible to require all Medicare recipients to enroll in HMOs, subject to availability. The American Association of Retired People (AARP) is a strong organization, and the elderly can bring strong opposition to bear on plans to restrict their choice of health care. The elderly have many advocates in Congress. Probably the best that can be done now is to offer an HMO option on a voluntary basis. On the other hand, politically it is easy to require Medicaid recipients to switch to an HMO, since there is no strong opposition group. Many people would be sympathetic to putting Medicaid recipients into HMOs, even if it were viewed as providing substandard care, because of resentment of providing free medical coverage to nonworkers.

Are we in trouble, and, if so, how serious is it?

How valid are the claims of our lack of health care coverage, and how serious a problem is it? Are we a nation in trouble, unable to offer minimal health care to our citizens? Do we give better health care to our welfare recipients and their children than to those who work but make low incomes? Or are the problems exaggerated? Are we being driven by anecdotal evidence, or do the stories merely represent the tip of a very unhealthy iceberg? Figure 3 shows the distribution of our health care coverage for our population.

Figure 3. Distribution of sources of health coverage



Consider those with no health insurance coverage. A recent study indicates that at least 14 percent of the population, or 17 percent under the age of 65, had no health coverage, private or public, in (during or throughout) 1994, and that this percentage has been rising for at least 6 years.²⁶ Why do these people have no coverage? Is it because they are young, and feel no need for coverage (even though they may be incorrect)? If they are choosing to gamble, is this a choice that they should be allowed to make? If so, and they later develop a need for medical care, are we willing to deny them care? Will we allow them to buy in after they reach a certain age, and have a family, or after they develop health problems? Are they rich? Or are they ineligible for health insurance? Do they perceive themselves as unable to afford health insurance, given the other demands placed on their financial resources? Are they children, and have no choice in the matter?

26. See *State Initiatives in Health Care Reform*, No. 11 [6]; the analysis is based on Census data.

According to a GAO study, the uninsured are concentrated among the lower income, minority, youth, unmarried, and less educated people [20]. The study found that a large majority are employed.²⁷ Although some of the employed uninsured were part-time, or part-year, workers, a substantial share worked full-time—over one-third of the uninsured between age 19 and 64 had full-time jobs. Only 15 percent of the uninsured had yearly incomes in excess of \$40,000. Evidence from a Department of Health and Human Services study offers supporting information. This study indicates that youth and low-income status are the best predictors of having no health insurance. About one-third of the uninsured were children under the age of 19 [21].

What about those who have insurance? Are they secure with all of their health care needs met? Unfortunately, this is not the case. About 13 percent of the population was covered by Medicaid for 1993 [22]. This segment of the population often has severe access problems, either in finding a source of medical care that will accept Medicaid patients, or in being able to arrange transportation to a health clinic or physician's office and arrange child care.²⁸ Another 13.5 percent of the population is covered by Medicare, which does not cover prescription drugs [23]. Prescriptions form a larger percentage of medical costs for the elderly than for any other age group. The elderly accounted for one-third of the spending on retail prescription drugs,

- 27. Callan and Yeager [15] agree, estimating that 60 percent of the uncovered are employed.
- 28. In general, Medicaid covers poor people, who are predominately young. Their major source of care for illness is the physician's office, not a hospital. For young people, utilization rates for hospital services are quite low. The main question, then, is how easy is it to get care in a physician's office or a clinic under Medicaid? The answer is that it varies greatly. First, the beneficiary must find a physician or clinic that accepts Medicaid patients. Then, he or she must wait for an appointment. Finally, there are transportation and child care issues that may constrain the beneficiary's ability to schedule and keep an appointment. In addition, there are forms to fill out to establish eligibility to use Medicaid, and these forms must be filed before the person can seek care under Medicaid coverage. Reports indicate that many people do not establish Medicaid eligibility until they need medical care.

or about \$24 billion, in 1992.²⁹ So about a quarter of our population faces the possibility of severe access problems or a high percentage of out-of-pocket costs.

Those with private insurance face similar problems. First, insurance generally covers only a portion of the cost of medical care. Deductibles, copayments, and payment for nonapproved procedures must be absorbed by individuals. In addition, if charges are above those accepted as usual, customary, and reasonable (UCR) by the insurance company, the person must absorb those excess charges. Insurance companies usually refuse to tell patients the UCR levels, and few patients have the sophistication or time to seek such information or query physicians and hospitals with regard to prospective charges. People may belong to a network of providers, or a managed-care plan, which will limit access to specialists and control use of hospital resources and outpatient facilities.

All insurance plans have types of care that are not reimbursed. Fee-for-service plans, for example, often do not cover preventive care, such as annual physicals, vaccinations, and birth control. HMO's typically do cover preventive care but restrict access to specialists. If a person wants to go outside the HMO for care for a specific condition, he or she must absorb all or a large share of the cost. In addition, most insurance plans have limits on the amount they will pay, in a given year and/or over a lifetime, for treatment of certain conditions. This ranges from an overall lifetime maximum, to annual limits for the amounts that will be paid for certain conditions, such as mental health, substance abuse counseling, or drug rehabilitation.

In addition, many policies exclude people for preexisting condition coverage, either for a period of time or for life. Some plans place limits on the number of days of hospitalization that will be covered. Some cover only hospitalization, while others cover only outpatient care. Prescription drugs may not be covered. Treatment for mental health problems or substance abuse may not be covered, or may be covered on a limited basis.

29. This came to over \$700 per person for the elderly in 1992 [24].

In terms of overall coverage, over a quarter of the population is covered through a government program, either Medicare or Medicaid. Another 14 percent has no formal mechanism of health coverage. Therefore, 40 percent of our population depends on primary coverage by the government or on less formal programs, such as government-sponsored public health clinics or charity. This means that a substantial part of our population already depends primarily on the government as a provider of health care, either through a formal program, or as a provider of last resort (show up at the emergency room and rely on charity).

Therefore, in addition to the large costs of Medicare and Medicaid, these groups of uncovered people are placing great stress on the system of health care. The uncovered tend not to receive regular health care, but seek care only when a serious condition develops. They may be seen at emergency wards, or in hospitals and clinics on a nonreimbursable, or charity, basis. Costs of this type must be covered somehow, usually in one of two ways: cost shifting to those with insurance, and through use of tax revenue to reimburse institutions for nonpaid care. Therefore, the government and private citizens pick up the tab.

What kinds of changes are we observing?

As private health care changes continue, the country will be in a far different situation in another decade. If current trends continue, individual beneficiaries will:

- Pay more for their insurance coverage (increased share for employees with employer-sponsored coverage, increased premium levels)
- Pay higher deductibles/higher copayments for coverage
- Face more restrictions on choice of physicians, hospitals, and treatments
- Use preferred provider networks for physicians
- See member hospitals reimbursed at higher rates

- Be increasingly denied treatment for specified conditions (not medically necessary, optional level of treatment, covered only as outpatient treatment, higher copayment category, etc.)
- Be increasingly covered by managed-care arrangements, such as HMOs and networks.

The implications for health care reform of the future are predictable. One major reason that the public lost faith in health care reform was that it became linked to fears that people would lose their existing coverage and be forced to accept inferior substitutes—such as managed-care organizations in place of private physicians. Given current trends, by the time health care reform is reconsidered, many of those now covered by indemnity plans will be covered by some form of managed care. Therefore, the fear of a managed-care takeover will be mitigated because it is likely to have already occurred via private sector negotiations of employers and insurers, and negotiations of federal and state governments with Medicare and Medicaid contracts.

In addition, the changes occurring are likely to create a larger pool of people who are uncovered or lose benefits as time passes. As coverage weakens, with more care being denied, and as more people are unable or unwilling to pay their share of employer-sponsored plans, we will see more people closed off from access to insurance. In addition, employers are pulling back from providing comprehensive coverage: they are less likely to pay the full cost of coverage, to pay for family members, to offer indemnity coverage, or even to offer health insurance.

Medicare and Medicaid recipients place other stresses on the system. The size of both groups is growing, and the costs attributed to each group are growing also. This places huge demands on state and federal budgets, and squeezes funding for other programs. Continued growth in costs for these programs make it very difficult to bring our national deficit under control. In addition, if the percentage who are Medicaid and Medicare recipients, and the percentage who are uninsured all continue to grow, clearly the pool of people with private insurance will shrink in a relative sense. This implies there will be a gradual shifting of the responsibility of health care expenditures from the private sector to the public sector.

The effect of the changes going on are likely to result in increased cost shifting. If more people lose health care coverage, they must rely on their own resources or seek care in an emergency room, hospital, or clinic as an uncompensated, or charity, patient. Those people paying for their own care—either directly or through purchasing private insurance coverage, will contribute to the increasing numbers who are uncovered via higher prices. Equally, all taxpayers share in the cost of providing care for those with no coverage as well. In either case, the result will likely be a decrease in the purchasing of health care services. The uncovered are less likely to get routine care, and the covered, facing higher prices, may purchase less care.

Is this a bad outcome? It depends on whether you believe that quality of care is likely to be seriously compromised in the above scenario. Our society might choose a lower quality of care in exchange for lower costs. Do physicians order unnecessary and duplicative tests, either to pad their bills or to defend against potential malpractice? Do people receive more care than they need? Data on this kind of question are woefully incomplete. Outcomes research may, or may not, indicate whether different protocols of treatment offer superior results for a specific disease. Such studies are often plagued by a lack of appropriate control groups. In any event, this does not give us a direct link to assessing the efficacy of care given under fee-for-service arrangements vice care given under managed-care arrangements.³⁰ In addition, we do not know how much people suffer from lack of care as uninsured individuals.

However, the incentive structures offer some guidance into what we can expect to occur. The structures seem to work in opposite directions—under fee for service, there is a financial incentive to providers to supply “too much” care. Under managed care, there is a financial incentive to providers to limit care to what is absolutely essential. The real question may be, do physicians know clearly what is an appropriate level of care, and can they be trusted to provide that care when faced with financial incentives to shave costs? And for those with no

30. See [19, pp. 184–186] for a discussion of comparing costs and services under HMO and fee-for-service arrangements.

insurance coverage, there is an incentive to not provide care except on an emergency or urgent-need basis.

One of the major themes coming from the recent health care reform debate is lack of coverage. People are clearly annoyed by the fact that, as they perceive it, those who are on welfare receive better health care protection than many of those who work.³¹ In fact, for those who work at low wages, health insurance availability is largely a function of working for a big company that provides health care for all workers. Those who work full-time, but who have a relatively low income, are unlikely to be able to afford an individual insurance policy, and may feel unable to afford their share of a group policy if it is available. Part-time workers rarely are eligible for employer-sponsored health insurance.

It is clear why many people are reluctant to give up benefits, or pay more taxes, in order to better insure those they consider to be a net drag on society rather than contributors. Those on welfare receive benefits that often sum to more than a full-time minimum-wage worker would earn in a year. And a minimum-wage worker is very unlikely to be able to afford health insurance, or even be offered a chance to purchase group health insurance.

31. Medicaid is generally available to those with very low incomes. Medicaid is not purchased, but is paid for entirely by the government. One of the difficulties with Medicaid is that it carries a perverse incentive for people receiving coverage: if they find work and their income rises above the cutoff level, they lose their entire Medicaid coverage, for themselves and for their children. This creates a trap effect: trying to work to get off welfare usually starts with a low-paying job, which may lift a person just far enough out of poverty to lose his or her health benefits.

Where do we go from here?

What are the issues?

At this point in time, our health care system has to be described as mixed. In the past, we decided that our system was broken at two points. It failed to deal adequately with problems of providing health coverage for the elderly—hence Medicare. We also concluded that we needed a system to deal with health care provision for the poor—hence Medicaid. The implicit assumption is that, if you are not elderly and not poor, you are expected to be able and willing to obtain adequate health care coverage without government intervention. The question to mull over is: are the remaining parts of our population adequately served? Or is there, in fact, a third failure to consider, that is, the 14 percent of the population with no health coverage?

The argument can be extended by asking if Medicare and Medicaid are adequate. This is a broader issue, regarding not just the provision of a system of care, but the value of the system (e.g., with regard to access, satisfaction, outcomes measures). If this argument is tackled, the adequacy of private insurance can legitimately be viewed as open to inquiry as well.

The basic issue, however, comes down to the provision of health care for those with no private insurance who are not under a safety net of Medicare or Medicaid. Can we assume that those who do not qualify under one of these programs have no special need for health care provision other than what they can obtain for themselves? And if the answer is no, how big a problem is it, and how many people are affected? As a nation, we must face the fact that there will always be people who fall through the cracks. We cannot, and should not, drive our nation down a path based on anecdotal evidence and/or special (and very rare) circumstances.

However, there are other issues to be considered here: if health insurance is unattainable for a substantial segment of our population, especially for those who work but cannot afford to pay premiums for health insurance, how can we justify subsidizing those who do not work? We give health coverage, of at least a minimal type, to those on welfare and/or in poverty via Medicaid. Is it appropriate to subsidize health care for this group, and leave low- to middle-income workers, self-employed workers, and many small business workers with no coverage? This is the issue that needs to be resolved.

The issue of justifying Medicare is somewhat different. Medicare recipients are elderly and face difficulties with insurance market incentives. They also contribute to their premium costs and pay substantial individual costs for health care.³²

Why do we have so many problems?

How did our health care system problems develop?

Does the current system facilitate the explosion of prices, premiums, and costs? One argument is that any system creating a wedge between the users and the providers, so that real prices are hidden, will be likely to generate inefficient outcomes. Our system is based largely on employer provided health insurance. This may be a good way to provide insurance, in that it allows an employer to buy for a group of individuals, but it also drives a wedge into the market mechanisms. The individual is not necessarily aware of the total premium paid by the employer. In addition, he or she is not aware of the price charged by physicians and hospitals, in advance of receiving services. Insofar as insurance companies pay on claims, with minimal involvement by individual patients, there is a general lack of information being shared across all relevant segments of the system.

32. They have contributed, in some sense, to at least some of the costs of their coverage through payroll deductions. They also pay part of the cost of coverage through premiums. They face controls via copayments and deductibles, and not all procedures and benefits are covered, such as prescription drugs.

According to Uwe Reinhardt [25], this disconnect of information facilitated rising prices for medical care.³³ Now pressures are being initiated to control the growth of prices, such as copayments, deductibles, and constraints on reimbursement—usual, customary, and reasonable (UCR) allowances and resource-based relative value scale (RBRVS). Although such measures may slow the rate of growth of prices, it is hard to see how they will actually diminish prices.

Joseph Newhouse [26] argues that a major cause of our spiral of health care costs is caused by the growth of technology. In this argument, new technology and increasing medical capabilities are viewed as the primary reason for our increasing medical costs. He concludes that so far, the public appears to have chosen to use new, improved technology, without much regard for the net gain in efficacy of diagnosis and treatment. If true, this implies that converting our health care system to managed care may only buy us a temporary dip in the rise of costs. Once the transition is over, the cost of medical services will rise again, unless global budgeting is used to stem the trend. However, this could be viewed as stifling innovation.

Other authors have argued that the disconnect between using and paying for services has facilitated an upward spiral of costs. Patients use services, while generally the government or insurance companies pay the bills. In this context, various arguments can be made for designing ways to control medical costs. One is to force consumers of medical services to see how much they are actually paying for services, in which case supposedly consumer reactions will serve to limit prices. However, this places a considerable burden on consumers, perhaps working through insurance companies, to gather information and price-shop at the time of needing medical care. Another way is to turn

33. While it is true that asking employees to pay a share of the premium, out of pocket, forces them to realize that they are at least partly paying for health care, employees still believe that the employer is paying the remainder. As reported by Uwe Reinhardt, every paycheck stub should state: "On your behalf, your company contributed this month \$X for your health insurance coverage, over and above your own contribution. If your company had not made this contribution, your take-home pay would have been \$X higher."

over the monitoring of the system to the central government, which will use general tax revenues to fund a minimum level of health care for all individuals. In this way, the collection of funding is simplified. However, the simplification means that people may still be unaware of how much they are contributing to health care costs. A modification of this method is to assess a special individual tax, based on income, at the time federal taxes are paid.

There is a natural problem with information flow. When you need health care help is not the time to price-shop. A problem with an inflamed appendix is not normally preceded by a lengthy period of time in which to call physicians, develop price comparisons, and make an appointment. In this case, insurance companies with preferred provider lists may act as an interface for the person. Precertified reasonable rates may be ascertained, combined with the ability to extract discounts based on a guarantee of a supply of patients.

Although we do not know how the ideal system would be configured, we have taken various steps to try to control costs. The following are important elements:

- Copayments
- Deductibles
- Clear knowledge of total cost of treatment
- Clear knowledge that individuals are paying for it, one way or another
- Significant cost-sharing of insurance premiums.

However, there are other issues to consider. It is not clear how private insurance mechanisms can deal with these kinds of problems:

- Cost shifting to compensate for care given to uncovered individuals
- Long-run health problems with lack of adequate care for target populations
- Natural incentive of private insurers to make a profit—avoid high-risk users.

How do we go about finding a solution?

The issue of providing health care is not one that can be delineated and decided, as if there is a single best answer. If there is a single best answer, we might fail to recognize it anyway or reject it because of lack of information. A solution to health care reform in the United States must be based on what is feasible at this point in time, not what would be an ideal solution. We have a given infrastructure, political process, and set of players. We have to learn to get the facts straight, find better information, and make decisions based on the needs of our people, compared to the costs that will be required.

This will require tough decisions to be made. In addition, it is not clear that we can do much better unless we are willing to consider changes to our system. However, it is probably not feasible to look at changes that overhaul our entire system at once. Health care reform, in this country, seems to occur in chunks. Medicare and Medicaid reflected major changes in our way of thinking, and our provision of health care. It is not clear what our next move should be. Do we want to try to bring everyone under the same umbrella? Or do we want to separate our population in subgroups, and manage health care differently for each group?

Universal coverage follows a single umbrella approach, while traditionally we have chosen to deal with subgroups, based on circumstances, needs, and resources. Do we want to continue with this approach, or will we decide that it is more efficient to deal with a single group of people, with a single set of rules? Or do we even agree that a single set of rules is appropriate, when it comes to the provision of health care? Perhaps we will conclude that different levels of health care services are appropriate for different subgroups.

As a nation, it is important for us to come to grips with what we want, versus what we can afford. Choices have to be made. Rationing will occur; it is simply a question of deciding how we want to ration care, and by what mechanism. These decisions will have significant implications for our people and for the health care institutions that serve our people.

Appendix: State health care reform

Discussion of ERISA issues

ERISA was enacted in 1974, essentially to deal with pension plan mismanagement problems. However, the law applies to all employee benefit plans, which includes health care plans. The difficulty with ERISA lies in section 514, the preemption clause, which states that ERISA provisions are to supersede all state laws “insofar as they may now or hereafter relate to any employee benefit plan”[3]. States are allowed to regulate traditional health insurers, but ERISA will not allow a state to categorize a self-insured employee benefit plan as an insurer, thereby bringing it under state jurisdiction.

It is not clear in retrospect whether the enactors of ERISA knew how it would affect state health care programs. The impact has become more clear, however, as reported by Butler [3]:

In effect, this ERISA qualification allows a company to be exempt from state insurance regulation and, through court interpretations, from many other state mechanisms necessary to control health care costs and improve access. Although under the McCarran-Ferguson Act states are still delegated the responsibility to regulate traditional insurers, plans that are self-insured under ERISA provisions are exempted from state oversight. (Nationwide, nearly two-thirds of the population insured through employment participates in self-insured plans.) To achieve universal coverage within a state, or implement even a less ambitious effort that affects all state residents, states must have the option to include every resident receiving health benefits. Without such flexibility, states will be unable to achieve the objectives of increasing access while controlling costs.

The language of section 514 clearly limits states from enforcing laws (other than regulation of traditional insurance carriers) that “have an intended and direct impact on self-funded employee plans [3].”

However, it is also not clear how indirect effects are to be treated. In addition to areas where ERISA clearly forbids state regulation, there are many areas of uncertainty, awaiting definitive court rulings, which cast a chilling effect on state reform efforts. Among the forbidden areas are [6, No. 13]:

- Employer mandates
- Regulation of self-insured employer health plans
- Insurance market reforms that affect self-insured plans.

Among the gray areas are:

- Pay-or-play plans
- Income taxes to finance coverage expansion
- Provider taxes
- Uniform data reporting and/or claims procedures
- Status of stop-loss plans—are they insured plans and therefore subject to regulation?

The four basic areas of state activity that may be affected by ERISA include:

- State financing—how to pay, who will pay
- Expenditure controls—how to constrain growth in costs
- Insurance reform—e.g., guaranteed renewability, mandatory community rating
- Program administration—need for current, detailed, accurate data on utilization and costs.

For state financing, many of the options under consideration as a mechanism to finance employer mandates, such as employer “play or pay,” or taxes on health plans or providers, are running into difficulties. They are sometimes inapplicable for employers and employees covered under ERISA plans, and in other cases, there are questions of validity due to lack of a clear court decisions, or conflicting decisions in different jurisdictions. For expenditure controls, such

strategies as provider rate-setting and global budgets—setting caps or targets for spending—have resulted in court challenges under ERISA.

Insurance market reform, such as guaranteed renewability and mandatory community rating, become ineffective because many state insurance plans, under ERISA, are exempted from state insurance laws. Finally, managing any kind of reform presupposes the availability of timely data to use to evaluate and adjust programs. However, ERISA's preemption for self-insured plans severely limits the ability to collect and use data. Such activities as collecting uniform data on health care use and expenditures from third-party payers, mandating uniformity of claim forms, and requiring electronic billing are not allowed.

While some activities are definitively stopped by ERISA, many are simply stalled because of the fear of an ERISA challenge. Court interpretations will be needed to settle many issues, but a state can be sure that many of the desired reform activities will draw forth a court challenge under ERISA. Short of waiting for lengthy court cases to wind to a clear resolution, which of course would take years and would not necessarily give states much latitude in handling reform activities in any case, Congressional action to modify ERISA would be required to alleviate the situation for states. However, such action appears to be unlikely.

Why would Congress be unlikely to modify ERISA, or add a section to allow waivers to ERISA? One reason is the constituency that supports continued existence of ERISA, both in general and specifically with regard to health care issues. Unions and big business interests are joined in not wanting ERISA to be modified to allow more state play in the health care reform arena. Many unions and businesses represent and employ people across various states. Individualized state reform packages, affecting a company's health care provisions differently in each state, would create management and union difficulties. Negotiated settlements would differ depending on the approaches taken by each state, and recent state reform efforts support the premise that states would choose different methods to attempt to achieve reform.

In addition, there are traditional political postures as well. Republicans are viewed as committed to the interests of the business community, which support maintaining ERISA. Democrats are traditionally tied to union interests, which also support ERISA. In addition, there is a theory that Democrats tend to mistrust what kind of reforms certain states might choose to implement, if given a free hand [27].³⁴ In this case, it is viewed to be better to have a national plan, or nothing at all, rather than allow states the freedom to select their own plans.

Even if a waiver system for ERISA were in place, there is no guarantee that states would find it easy or feasible to obtain ERISA relief. When ERISA was implemented in 1974, Hawaii was working to provide universal health care coverage for its people. This was designed via employer mandates to provide coverage for workers. Even though Hawaii is isolated, and unable to affect neighboring states, it took over 6 years for Hawaii to obtain a federal waiver exempting ERISA control for this area. In fact, one of the Republican candidates for president this year has advocated reversal of Hawaii's ERISA exemption for health care.

The Hawaii health care system

Hawaii is the only state with an exemption from ERISA and, consequently, the only state that has been allowed to implement measures to provide near-universal coverage to its citizens. The fight to achieve the ERISA exemption was not trivial. It took over 6 years for Hawaii to obtain its exemption, and the exemption was undoubtedly given in part because Hawaii is relatively small and very isolated from the rest of the United States.

Hawaii's health care reform efforts may offer insights for the rest of the states, but they can scarcely be viewed as a general template, in that Hawaii does not have the inherent problems and pressures that would be faced by other states. There are no adjacent states with

34. Emily Friedman made these comments at the June 1995 AHSR & FHSR Annual Meeting in Chicago. She was one of the speakers for the session entitled "State Reform Initiatives: Fertile Ground for Health Services Research."

different health care systems to worry about. There are no alternative sources of care than those provided by Hawaii, unless a person wishes to travel to the mainland. There are no problems with families who work in one state, but live in another. Although there are problems that can arise, such as children who live outside of Hawaii, the general isolation of Hawaii makes it much easier to manage a state health care system with minimal problems.

However, even Hawaii's health system leaves some holes in terms of universal coverage. The terms of the requirements for health coverage still drive off of the employment system, and do not require individuals to maintain coverage for dependents. Also, there are limits on coverage that, although they will provide adequate coverage for most individuals, could leave people uncovered in situations of severe health problems. In other words, universal coverage does not mean coverage for all people, and for every condition. What it probably means is, access to coverage for almost all people, and a minimum bound on coverage for those covered.

In 1991, while the national average for noncoverage was about 14 percent, only 4 to 7 percent of Hawaii's residents were estimated to lack health coverage [7]. Hawaii achieves this partly because it is the only state that has mandated employers to provide health insurance. Hawaii supplements this effort with public programs. However, there remain some residents with no coverage, and as is true for other states, having coverage does not guarantee access to care. Hawaii's mandated employer coverage is based on the 1974 Prepaid Health Care Act (PHCA). Hawaii's limited exemption from ERISA allows it to require employers, even those who self-insure, to provide minimum coverage levels to employees.

The employer mandate to provide health insurance to employees is actually based on a sharing of costs between employer and employee. The employee contributes the smaller of 50 percent of the premium cost, or 1.5 percent of gross wages earned. In 1991, the total premium for an individual covered by a small business employer would be about \$1,100. Employees are required to take this insurance unless they have alternate equivalent coverage.

Employers may choose between two types of coverage. They can provide a full major medical policy, but if this is the option chosen, the employer is not required to pay for coverage for dependents. Alternatively, the employer can offer a minimum floor benefit package, but in this case is required to pay at least 50 percent of the cost to cover the employee's dependents. Note, however, that in neither case is the employee *required* to take coverage for dependents.

To supplement employer coverage, Hawaii uses Medicaid, covering those with an income up to 62.5 percent of the federal poverty level.³⁵ In addition, in 1989 the State Health Insurance Program (SHIP) was set up to provide voluntary coverage to low-income people not eligible for Medicaid and not covered by an employer. Under SHIP, the state paid the full premium for those under the federal poverty level, but required some share to be paid by the individual for those between 100 and 300 percent of the federal poverty level. Under a 1993 waiver for a public health care demonstration project, Hawaii's QUEST project was designed to roll part of the Medicaid population and the SHIP population into a managed-care delivery system.

Hawaii's employer mandate excludes part-time workers (less than 20 hours per week), government employees, the self-employed, and certain low-income workers. These low-income workers include those with a monthly income less than 87 percent of the minimum wage, seasonal agricultural workers, and real estate and insurance employees who work on commission, among others. Also, some workers have temporary gaps in coverage due to waiting or enrollment periods. Unemployed workers may feel unable to pay premiums for coverage.

Hawaii's history offers some insight into the viability of an employer mandate for health care. Hawaii has a history of strong labor unions and large plantations, which often employed physicians to provide free employee health care. This tradition of employer-provided benefits implies that Hawaii may have always had an above-average level

35. The income level cutoff varies by state. Each state sets eligibility requirements and the scope of covered services. There are minimum eligibility requirements, e.g., states must cover those eligible for Aid to Families with Dependent Children.

of coverage, compared to the United States as a whole. Requiring eligible employees to take health insurance coverage (and share in premium cost) was a new element in Hawaii's mandated employer coverage.

What impact has this had on Hawaii? In many respects, not much. Hawaii's rate of growth of health care costs has paralleled that of the United States as a whole. In addition, Hawaii's per capita spending on health care is similar to the national average. What is different is that health insurance premiums are below the national average, and have grown more slowly than the national trend. Also, small business premiums are similar to premiums for large employers in Hawaii. In general for the United States, small business premiums are considerably higher than the premiums paid by large employers.

One explanation for this difference is that in Hawaii, there is by construction a smaller amount of cost shifting. The cost of providing uncompensated care can be passed on to patients with private insurance coverage, which drives up the premiums for insurance. However, in Hawaii, the small percentage of uncovered residents means that fewer costs need to be shifted in this fashion. Also, the requirement that all eligible employees take insurance coverage does not allow healthy individuals to attempt to game the system by opting out of coverage. This spreads total costs over a larger risk pool of people.

Although it is difficult to generalize from Hawaii's limited experience, especially given its isolated environment, it can be noted that Hawaii's per capita health care costs are no higher than the rest of the United States, even though there is a higher cost of living in Hawaii, and that a much higher percentage of people have health coverage. Businesses have not failed in droves, and small businesses manage to obtain health policies at rates similar to those for large companies. Hawaii's employers have not turned to part-time workers to avoid providing insurance coverage. Finally, premium costs are lower for Hawaii than for the United States in general. Therefore, firms continue to operate with no great difficulty in a climate of employer/employee-mandated health insurance coverage. The main difference is that Hawaii has far fewer people with no health care coverage than is true for the United States as a whole.

Washington's efforts at health care reform

Washington's 1993 Health Services Act was an attempt to provide a template for universal coverage for state residents. It included provisions for employer and individual mandates for providing and obtaining health coverage, a comprehensive uniform benefits package, and insurance premium caps. The move to universal coverage was to be phased in over a number of years, with more people being swept into coverage each year, and universal coverage achieved by the turn of the century. The plan also included subsidized health coverage for adults with incomes up to 200 percent of the poverty level, and Medicaid expansion for low-income children (in families of up to 200 percent of the poverty level). Other provisions included market reform efforts to provide guaranteed issue and renewability, to limit preexisting condition periods, and to require community rating for small businesses and individuals.³⁶

Why is Washington interested in providing universal coverage? As reported in the 1994 *Washington State Public Health Report* [28]:

- As of March 1991, 22 percent of those under age 65 said they had no private health insurance.
- In 1990, approximately 551,000 residents had no health insurance.
- A quarter of those without health care coverage of any kind are children.
- Administrative services account for almost 30 cents of every dollar spent on personal health costs for some insurers.
- The \$13.4 billion spent by residents on health care in 1990 (about \$2,700 per capita annually) tripled the amount spent in 1980—an average annual increase of 11.6 percent.

However, there were various factors that affected the execution of the plans, culminating in May 1995, when the legislature voted to repeal

36. The community rating can be modified by age, family size, geography, and "wellness activities." See [6, No. 13].

much of the 1993 Health Services Act. The experience of Washington state is an example of the difficulties inherent in trying to implement state health care reform. First, the existence of ERISA doomed the use of employer mandates for health coverage. Washington held back on the planned implementation schedule because it was clear that the state could not survive an ERISA challenge [8]. Why did the state rely on employer mandates? Clearly, it was hoped that ERISA would either be amended or modified with a waiver process that could be sought.

Second, the hazards of relying on state reform are demonstrated by the reversal of much of the planned reform by the new legislature. The May 1995 legislation eliminated employer and individual mandates, the comprehensive uniform benefits package, and insurance premium caps. In addition, the legislature abolished the Health Care Commission and replaced it with a Health Care Policy Board, designed to serve in an advisory capacity. Why were the reform efforts reversed so quickly? Several factors apply to this case:

- National (Clinton) health care reform failed.
- Government intervention fell out of favor.
- Interest grew for “market-led” change.
- There was no federal interest in allowing ERISA waivers.
- The legislature changed, and a new agenda appeared.

There are still some measures going forward to expand access to health insurance coverage. The Basis Health Plan is still in play. This plan attempted to expand subsidized insurance by enrolling adults earning less than 125 percent of the federal poverty level at minimal fees, with those earning 125 to 200 percent of the federal poverty level paying on a sliding scale. Plans continue to expand Medicaid coverage to low-income children (those in families at 100 to 200 percent of the federal poverty level), paying with cigarette and alcohol taxes. In addition, the market reform efforts are still in play.

However, as reported by William J. Hagens, senior research analyst with the Washington House Health Care Committee, the market reforms are ineffective without the other major reform efforts. “What do you have? You have the three darlings of insurance reform. What

does this mean in a market with no minimum benefits package?"³⁷ His opinion is that prices could simply escalate so that the insurance packages will be impossible to afford. If reforms mandate that coverage be made available, but do not constrain the benefit level or the price of the coverage, they are meaningless. Offering coverage at a very high price is a meaningless gesture to those with low- to middle-level incomes.

The Maryland health care system

Since the early 1970s, Maryland has embraced a regulatory approach to health care. Facing the continuing challenges of escalating health care costs, ensuring access to care, and maintaining quality, Maryland has responded with three separate pieces of legislation that focus on nearly all components of the state's health care system. The state directed its earliest regulatory efforts mostly on the hospital industry. Those undertakings included the establishment of an all-payer, rate-setting program and a certificate-of-need program. Recently, Maryland passed legislation that directly affects insurance companies and physicians.

Each regulatory effort is directed by an independent commission, as follows:

- The Health Services Cost Review Commission (HSCRC) oversees the hospital rate-setting activities.
- The Health Planning Resources Commission (HPRC) administers the Maryland certificate-of-need program.
- The Health Care Access and Cost Commission (HCACC) directs insurance and practitioner payment reforms.

Commission members are appointed by the governor and historically have enjoyed relatively little political interference. We will examine each regulatory effort in the sections that follow.

37. See p. 157 of the *Washington State Public Health Report*, 1994 [28].

Hospital rate-setting

Maryland was the first state to attempt “public utility” regulation of hospitals. Rate control bills were introduced in the Maryland State Legislature as early as 1967; however, it was not until 1971, when the Maryland Hospital Association supported the program, that the bill was enacted into law [29].³⁸ The legislation created the Health Services Cost Review Commission (HSCRC) to develop the Maryland all-payer program. The enabling legislation granted three broad areas of responsibility to the HSCRC:

- Public disclosure of the financial conditions of hospitals
- Rate review/rate setting
- Trustee disclosure.

Our interest in the commission is concentrated in its rate review and rate-setting functions.

The HSCRC began reviewing and approving hospital rates in 1974 after a three-year phase-in of a uniform accounting and reporting system.³⁹ During that time, the commission also applied to the Department of Health and Human Services for a waiver from Medicare and Medicaid reimbursement principles in favor of the state’s rate-setting system. The DHSS granted Maryland the waiver effective 1 July 1977, giving the commission control over all payers. Congress made the

38. Financial distress among Maryland hospitals played a major role in the establishment of the state’s rate-setting system. In addition, they were concerned that some form of federal regulation would be imposed upon them. For the most part, the hospital industry in Maryland has supported and collaborated on state rate-setting efforts since the beginning of the program [8].
39. During that time, 22 states adopted some type of hospital rate-setting activities. Much of the regulatory activity following Maryland’s efforts came in response to federal encouragement via section 222(b) of the 1972 Social Security Act amendments. Section 222 supported state-initiated efforts to establish a variety of innovative payment demonstrations, such as incentive reimbursement demonstrations, voluntary and mandatory rate-setting programs, alternative care demonstrations and other innovative approaches to health care cost containment [30].

waiver permanent in 1983, provided that the state meets certain conditions. The system must remain all-payer, and the rate of increase in Medicare payments per admission in Maryland must remain below that for the nation [31].

Maryland's rates are mandatory and apply to all acute-care inpatient, emergency, and outpatient services provided by hospitals. The commission sets rates for each department within each hospital and adjusts them annually for inflation, volume changes, and productivity gains [31]. During the first several years of the program, the HSCRC conducted a detailed review of each hospital's budget and established rates on a per service basis. In 1976, the commission began shifting to a guaranteed inpatient revenue program, which regulates revenue per case adjusted for case mix [9].

The primary goal of Maryland's system is to control hospital costs. In 1976, Maryland's cost per discharge was 26 percent above the national average. Since the implementation of their all-payer, rate-setting system, the state has achieved average costs per discharge lower than the national in average. In 1990, Maryland's cost per discharge had dropped to 6 percent below the national average, and in 1992, the cost per discharge was 14 percent below the national average in 1992 [9, 11].

However, examining hospital expenditures in Baltimore on a per capita basis, Anderson [11] found that rate-setting appears to have had a greater impact on hospital productivity between 1971 and 1990 than on controlling costs. Between 1971 and 1990, the annualized rate of increase in hospital costs per capita was 10.5 percent in Baltimore compared to 11.2 percent nationwide. Alternatively, the annualized increases for hospital expenditures between 1971 and 1990 was 8.21 percent for Baltimore compared to a national average of 10.72 percent.

Anderson attributes most of this difference to slower rates of growth in the number of FTE personnel per occupied bed and in the payroll expenditures per employee. Anderson also notes that his results "are similar to previous evaluations of state prospective payment system, which have found that such systems have lowered the rate of increase

in hospital expenditures per discharge by 2 to 4 percent per year and have increased hospital productivity” [11, p. 74].

As a regulator of all-payers, the Maryland rate-setting payment system also prevents cost shifting among payers and achieves an equitable distribution of uncompensated care. Typically, Medicare, Medicaid, and Blue Cross do not pay for costs associated with charity care and bad debt, leaving the costs of uncompensated care to be shifted to private payers and other insurers. However, under the Maryland system, all payers share the burden of uncompensated care. In addition, in a recent review of the literature on hospital rate-setting, Anderson [12] found that rate-setting systems have achieved expanded access to services for the uninsured. Currently, Maryland is the only state maintaining an all-payer, rate-setting system.

Hospital capital investment

Maryland was among the first states to adopt a certificate-of-need (CON) program aimed at controlling the expansion of hospital facilities and services. The main focus of CON programs is to control health care costs by preventing the oversupply of health care resources. CON laws became more widespread among the states following the passage of the Public Health Service Act of 1974. Maryland’s program, which began in 1970, predates this federal legislation. In brief, the act encouraged states to adopt CON laws by tying them to eligibility for federal public health services funds.

Title XV of the act required health care institutions to receive prior approval from local health services agencies and from state planning agencies before expending capital on new equipment, renovations, and construction exceeding \$150,000 [32]. In addition, hospitals had to demonstrate full use of existing resources before purchasing additional health service resources. During the deregulation efforts of the Reagan administration, Congress repealed the act, effective in 1987. Despite the elimination of federal funding, a number of states, including Maryland, continue to operate CON programs.

The Maryland Health Resources Planning Commission (HRPC) maintains the state’s CON program. Maryland requires that a health care facility obtain a CON before it may:

- Build, develop, or establish a new facility or relocate a facility to another site
- Change its bed capacity
- Add a new type of health care service
- Change the scope of an existing health care service
- Establish an additional home health agency or service
- Incur capital-related expenditures exceeding a defined threshold (\$1.25 million in 1994) [31].

The HRPC will grant exceptions to CON requirements if a hospital is funding a project predominantly out of its existing rate structure. Maryland does not require hospitals to obtain a CON for expenditures related to the purchase and installation of major medical equipment. The HRPC also approves hospital mergers. The Commission may waive the full CON review process if it finds that the merger is in the public interest, will result in more efficient and effective delivery of health services, and is consistent with the state health plan.

Insurance and physician payment reform

On 9 April 1993, Maryland lawmakers enacted legislation that deals with rising health care costs and inadequate access to health insurance coverage through regulation of insurance carriers and health care practitioners [13]. The legislation created the Health Care Access and Cost Commission (HCACC), the newest of Maryland's independent commissions responsible for conducting regulatory health care efforts, to implement the actual reforms. The HCACC's primary areas of work are:

- Promoting small-group market reform via the introduction of a comprehensive standard health benefit plan
- Developing a medical care database on all nonhospital health care services
- Creating an HMO quality and performance measurement system

- Encouraging administrative simplification via certification of electronic claims clearinghouses
- Developing a resource-based relative value scale (RBRVS) payment system for Maryland physicians
- Designing practice parameters specific to the state of Maryland [13].

We discuss each initiative in some detail below.⁴⁰

Small group market reform

The new Maryland law requires carriers to offer the same standard benefit plan with the same general cost sharing features to all small employers with 2 to 50 employees who work at least 30 hours per week. The intent of small-group insurance reform is to enable employers to make better (more informed) comparisons across carriers by having a uniform benefit with the same cost-sharing arrangements. This also forces carriers to participate in the small-group market if they want to sell insurance in Maryland. The enabling legislation mandates that the standard benefit plan provide at least those benefits required to be offered by federally qualified HMOs and that the average rate of the plan may not exceed 12 percent of Maryland's average annual wage. The average plan rate in 1995 is \$3,100.⁴¹

Developed by the HCACC in 1994, the plan has a single set of benefits applicable across four delivery systems (indemnity, preferred provider, point-of-service (gatekeeper) system, and HMO). The uniform benefits combine an emphasis on preventive care characteristic of HMOs and protection against catastrophic loss characteristic of traditional indemnity plans. Table 1 lists the range of services provided under the mandated benefit structure. The uniform benefit replaced all benefit plans sold in Maryland beginning 1 July 1994. Persons may purchase more coverage than the standard plan includes but may not

40. Unless otherwise noted, our research of the HCACC draws primarily from the following sources: Sammis, 1995 [13]; Maryland HCACC, 1995 [33]; and Anderson et al., 1993 [12].

41. Over all packages purchased, individual plus group.

buy less. During the first year of implementation of the standard health benefit, the HCACC observed that there was significant price competition among the insurance carriers and that purchasers of plans were shifting from traditional indemnity and HMO delivery systems to a managed-choice PPO system.

Table 1. Range of services covered under Maryland's comprehensive standard health benefit plan

Hospitalization	Infertility services
Emergency room services	Nutritional services
Outpatient hospital care	Medical food
Same-day surgery	Family planning
Preventive care	Pregnancy
Home health care	Mental health and substance abuse
Hospice	Prescription drugs
Durable medical equipment	Transplants
Laboratory	Ambulance service
Outpatient short-term rehabilitation	Physician services
Habilitative services	Chiropractic care
Skilled nursing facilities	No preexisting condition limitation ^a

a. Effective 1 January 1995

Source: HCACC pamphlet on Maryland's comprehensive Standard Health Benefit Plan for Small Businesses

Medical care database

The enabling legislation directs the HCACC to collect information on patient encounters with a practitioner or office facility and with pharmacies. The HSCRC already is trying to collect data on hospital inpatient and outpatient services. Therefore, the HCACC will collect information on every health care encounter in the state that is not collected by HSCRC. At a minimum, the database will include the following types of information: patient demographics, principle diagnosis, procedures, date of care, location of care, charge for care.

To assist in the development of the database, the commission formed the Maryland Medical Care Database Development Working Group. The group is composed of representatives from various health care

interest groups. The commission also has contracted with several technical consultants to assist with the database planning, data collection, and administration of physician surveys. The database will serve as a resource tool for use in examining cost questions and developing cost containment strategies.

The commission is required under law to use this database to publish an annual report of physician fees, beginning 1 October 1995. To meet the 1 October deadline, the commission has adopted an incremental implementation approach for establishing the medical care database. Initially, they will use data that are currently being collected for Medicare, Medicaid, and ten commercial payers in the state.

HMO quality and performance measurement system

The statute requires the HCACC to collect data from HMOs for use in HMO quality and performance system requirements. The commission draws from a number of sources to develop this system: the Group Health Association of America (GHAA), the National Committee for Quality Assurance (NCQA), and HMO enrollees. From these sources, the commission acquires objective and subjective quality measures. Specifically, the commission uses the Health Employer Data Information Set (HEDIS) developed by the NCQA to obtain objective measures of quality, access to care, membership and utilization, and enrollee demographics.

During 1994, the commission sponsored a pilot project in which 5 HMOs collected HEDIS data. Because HMO providers do not typically file a claim, the commission found that all 5 HMOs experienced problems in collecting the required data. The commission will extend the HEDIS collection requirements to all 19 HMOs in Maryland in 1996 to be submitted to the state in early 1997. The HCACC then will conduct an audit of the data for accuracy.

The HCACC also is developing an enrollee and practitioner survey to obtain subjective measures of quality. They have contracted with the Research Triangle Institute in North Carolina to develop the questionnaire and to survey a sample of enrollees from all 19 HMOs. The HCACC anticipates using these data sources to publish a consumer report card in 1997.

Administrative simplification

The overall cost of health care is adversely affected by the administrative burden placed on providers who must sift through a multitude of claims forms used by various insurers. In addition, the use of multiple claims forms requiring different types of information makes it impossible to develop a useful statewide health care database. To address these issues, the commission has the authority to limit the number of claims clearinghouses, to establish a uniform claims form, and to develop a statewide electronic claims transfer system. The commission plans to begin certifying claims clearinghouses by the end of this year.

RBRVS payment system

The legislation requires the commission to develop a resource-based, relative-value system (RBRVS) for use in determining physician payment amounts. Use of the RBRVS will be mandatory for calculating payments for all physicians in Maryland. In developing this system, Maryland will be building from the Medicare RBRVS. The Commission will derive payment amounts by multiplying three factors:

- A provider-specific component representing the resources necessary to provide the health care service (the resource-base)
- A procedure-specific component based on Current Procedural Terminology (CPT) codes reflecting the relative value of the service
- A conversion modifier that translates the value to a dollar amount.

The commission is responsible for determining the value of the resource base and relative values. However, the commission will negotiate with providers on setting the conversion factors. If the commission determines that the conversion factors are too high, they are authorized by law to adjust the conversion factors. Maryland physicians are concerned about the development of the RBRVS payment system and are opposed to the commission exercising its authority to adjust conversion factors. The target date for the system to be fully implemented is January 1997.

Practice parameters

Maryland has created a 15-member advisory committee to study and recommend the adoption of practice parameters for use in the state. The commission may adopt a recommended parameter if all three of the following conditions are met:

- At least 60 percent of the specialists in the area vote in favor of the parameter.
- The parameter is consistent with standards of care and discourages inappropriate utilization.
- The parameter defines a treatment method in an area of significant malpractice.

The intent is for the parameters to serve as guidelines to the medical community to reduce unnecessary care and costs. Use of the practice parameters is strictly voluntary. They will serve simply as a reference point, serving as a guideline to physicians, effective for three years. The parameters will not be legally binding and cannot be introduced in legal malpractice suits by either the plaintiff or the defendant. Currently, no practice parameters are in effect.

Lessons learned from Maryland

Maryland's experiences in the evolution of its state health care system span nearly 30 years. Maryland has chosen not to wait for the federal government to take action with respect to health care policies. Each legislative effort was state initiated. Each effort also has had the support of various health care interest groups, though never all of them. The combination of grassroots and business support has been crucial to successful legislative action.

From the early 1970s, Maryland has adopted a regulatory approach to health care reform. One HCACC official noted that the emphasis of the work in Maryland is, and has always been, on establishing mechanisms to make marketplace forces work. One element that has been critical to Maryland's continuing efforts is its avoidance of ERISA regulations. By focusing on insurance reform rather than employer mandates, Maryland has taken an approach that does not require an

ERISA waiver. All other states that have included employer mandates in their reform plans have stalled. The employer mandate has proved to be the kiss of death for any reform effort. Maryland is showing there is much states can do to reform their health care systems without coming near the employer mandate issue.

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